

Immunization Record

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| --- |
| **Client Information** |
| Last Name | First Name | M.I. | Date of Birth | | | Age |
| Address |  **M**   **F** **Other**  |
| City | State | Zip | Phone: |
| Do you have insurance? If yes name of company: | Insurance ID#: | Payment $ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cash Check Credit Card |
| Do you have a financial hardship?Yes No  | Are you disabled?Yes No  |  |
| **Race:** American Indian/ Asian Native Hawaiian/ Black/ White Other  Alaskan Native Pacific Islander African American  |
| **Ethnicity:** Hispanic or Latino Not Hispanic or Latino |
| **Primary Language Spoken: Vaccine(s) Requested: Flu COVID Other** |
| **Risk Assessment** – Please review and **circle** as appropriate. **If YES, *explain briefly.*** |
| * Have you had a serious reaction to any immunizations in the past? (Please specify)
 | No | Yes |
| * Do you have a history of Guillain-Barre Syndrome?
 | No | Yes |
| * Have you been sick with a fever in the last 3 days?
 | No | Yes |
| * Are you pregnant, or think you might be?
 | No | Yes |
| * Are you allergic to Thimerosal?
 | No | Yes |
| * Are you immunocompromised?
 | No | Yes |

**Consent**

* I agree to remain fifteen (15) minutes following immunization, and I certify the information is correct.
* I give permission for Northern Light Home Care & Hospice to administer the vaccine(s).
* I have read or had explained to me the current Vaccine Information Statement.
* I have had the opportunity to ask questions and understand the benefits and risks of vaccination.
* I authorize the release of any medical or other information necessary to process a claim for insurance payment.
* I understand that I may be responsible for charges not covered by my insurance provider.
* I have received or have been offered a copy of the agency’s Notice of Privacy Practices.
* I request that the vaccine(s) be given to me or to the person named above, for whom I am the legal guardian.
* I understand that I am liable for the vaccine and administration costs. My insurance company may cover all or a portion of this cost depending on which plan I have.

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**Signature** of client or person authorized to make request (parent or guardian)

**Administration**

In Home Use: Client SP or HOS#

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date | Vaccine Type | Manufacturer | Lot # | Dose Volume | Body Site | Route | VIS Date | Signature and Title of Vaccinator |
|  | Flu |  |  |  |  |  |  |  |
|  | COVID |  |  |  |  |  |  |  |
|  | Other  |  |  |  |  |  |  |  |

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