IMMUNIZATION REPORTING FORM for Nursing Homes

ARKANSAS DEPARTMENT OF HEALTH
4815 West Markham St. SLOT # 48 Little Rock, AR 72205-3867
Tel: (501) 537-8969 Fax: (501) 661-2300

NHImm (Revised 07/2021)

Clinic Code for Providers ☐☐☐☐

Nursing Home Clinic Code if ADH administers ☐☐☐☐☐☐

Date Vaccine Administered ☐☐/☐☐/☐☐☐☐

Patient should be screened for contraindications prior to receiving any influenza or pneumococcal vaccine.

Screening Checklist for Contraindications to Inactivated Injectable Influenza Vaccination (immunize.org)

Screening Checklist for Contraindications to Vaccines for Adults (immunize.org)

1. Patient Information: Last Name (apellido) ______________________________ **First Name** (nombre) ______________**MI** ___

Gender (género): ☐ Male ☐ Female **Date of Birth** (fecha de nacimiento): ☐☐ / ☐☐ / ☐☐☐☐

Race: (raza) ☐ Asian/Pacific Islander ☐ Black/African American ☐ Native American/Alaskan Native ☐ White ☐ Other

Ethnicity: (origen étnico) ☐ Hispanic ☐ Non-Hispanic

Address: (dirección) (Omit address and phone number if nursing home resident) **Apt. No.** (número de apartamento)

City (ciudad) **State** (estado) **Zip Code** (código postal)

Phone Number (teléfono) ☐☐☐ - ☐☐☐ - ☐☐☐☐

2. Insurance Status (Check appropriate box)**:** (estado de seguros, Compruebe la caja apropiada):

(Enter both Medicare Number and Medicaid Number including any other insurance information if applicable)

☐ Medicare Number (número de asistencia médica)

☐ Medicaid (número de seguro de enfermedad)

☐ Private Insurance (name): ____

Insurance ID Number (Número de identificación de seguro)

Insurance Group Number (Número de Grupo de Seguros)

☐ No Insurance (Ningún Seguro)

3. Release and Assignment *(Publicar y Asignar)*

- I have read or had explained to me the Vaccine Information Statement (VIS) for the Inactivated Influenza Vaccine and for the Pneumococcal (PPSV23) Vaccine as applicable and I understand the risks and benefits. To read the current VIS for each vaccine, visit the website https://www.cdc.gov/vaccines/hcp/vis/current-vis.html.
- I give consent to the State/Local Health Department/Nursing Home Facility and its staff for the individual named at the top of this form to be vaccinated with any of these vaccines.
- I hereby acknowledge that I have reviewed a copy of the Privacy Notice from the Arkansas Department of Health.
- I understand that information about these vaccines will be included in the Arkansas Department of Health's Immunization Registry.

To My Insurance Carrier(s):

- **I authorize the release of any medical information necessary to process my insurance claim(s).**
- **I authorize and request payment of medical benefits directly to the Arkansas Department of Health, if applicable.**
- **I agree that the authorization will cover all medical services rendered until such authorization is revoked by me.**
- **I agree that the photocopy of this form may be used in lieu of the original.**

Signature of Patient/Guardian for **seasonal flu** (Firma):________________________________Date: ____________________

Signature of Patient/Guardian for **Pneumococcal (PPSV23) vaccine** (Firma):____________________________Date: ___________

MFG Codes: SEQ = Seqirus, SKB = GlaxoSmithKline, PMC = Sanofi, MED = Medimmune, Merck = MSD

Site Codes: Right Deltoid = RD, Left Deltoid = LD, Right Arm = RA, Left Arm = RA, Right Leg = RL, Left Leg = LL

Seasonal Influenza (Preservative Free ≥ 3 years)

Seasonal Flu Vaccine	Route	Site Code	Dosage mL.	MFG Code	Lot Number	Signature /Title of Vaccine Administrator
	IM		0.5			

Pneumococcal (PPSV23)

Pneumococcal Vaccine	Route	Site Code	Dosage mL.	MFG Code	Lot Number	Signature /Title of Vaccine Administrator
	IM		0.5			