NURSING HOME IMMUNIZATION REPORTING FORM

Note: Nursing home facilities with access to WebIZ should enter the administered influenza and pneumococcal vaccines in WebIZ. Those forms do NOT have to be sent to ADH. Retain a copy per the Nursing Home policy.

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 ☐ NativeAmerican/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

- Only Uninsured Nursing Home residents should receive the influenza and pneumococcal vaccines supplied by the Arkansas Department of Health (ADH). Only uninsured Nursing Home employees should receive the influenza vaccine supplied by the ADH. Please refer to the Adult Immunization Schedule by Age | Vaccines & Immunizations | CDC for pneumococcal vaccine recommendations.

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 (PCV20) Vaccine as applicable and I understand the risks and benefits. To read the current VIS for each vaccine, visit the website Current VISs | Vaccines & Immunizations | CDC
- I give consent to the State/Local Health Department or 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. (If ADH administers the vaccines)
- I understand that information about these vaccines will be included in the Arkansas Department of Health's Immunization Registry.

Signature of Patient/Guardian for **seasonal influenza** (Firma):_____Date: _____

Signature of Patient/Guardian for **Pneumococcal (PCV20) vaccine** (Firma):____Date: _____

MFG Codes: PFR= Pfizer, 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 ≥ 6 months)

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

Pneumococcal (PCV20) NH residents ≥ 50 years who have not previously received any pneumococcal vaccine or whose previous vaccination history is unknown.

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

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