

# INFLUENZA VACCINE 2018-2019 HEALTH SCREEN & PERMISSION FORM

NPI: 1265651814-002

School Name: \_\_\_\_\_

*Full Name:		*Date of Birth: / /	Age:	*Gender: <input type="checkbox"/> M <input type="checkbox"/> F
*Street Address:		*Town/City:		*Zip Code: Daytime Phone:
Grade:	Teacher:		School Administrative Unit (District)	

**\*Required**

Is this person an American Indian or an Alaskan Native?  yes  no

Is this person uninsured?  yes  no

Is this person insured by MaineCare (Medicaid)?  yes  no

MaineCare ID #: \_\_\_\_\_

Private Insurance?  yes  no

Name of Insurance Company: \_\_\_\_\_

ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Please answer the following questions about the person named above. Comments may be written on the back of this form.

	YES	NO
1) Does this person have a severe (life-threatening) allergy to eggs?		
2) Has this person ever had a severe reaction to an influenza immunization in the past?		
3) Has this person ever had Guillain-Barre Syndrome?		

If you answered "yes" to any questions 1-3, please see your healthcare provider for influenza vaccination

### PERMISSION TO VACCINATE

- I was given a copy of the Influenza (Flu) Vaccine Information Statement, I have read this or had this explained to me and I understand the benefits and risks of the Influenza vaccine.
- I give permission for a record of this vaccination to be entered into the ImmPact Registry.
- I give permission for information to be used to bill MaineCare or private insurance for the cost of providing the vaccine
- I give my consent for this person to receive the most appropriate vaccine, as determined by the health care clinic staff.
- I give permission for the flu vaccine to be given to the person named above by signing below.

X \_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent or guardian if person to be vaccinated is a minor or Signature of adult to be vaccinated

Printed Name of Parent or Guardian: \_\_\_\_\_

**FOR OFFICE USE ONLY:**

Date Dose Administered	Vaccine Manufacturer	Lot Number	Dose Volume	Signature and Title of Vaccinator	Body Site	Route	VIS date
/ /						<input type="checkbox"/> IM single dose <input type="checkbox"/> IM multi vial	State Supplied Y N