

INFLUENZA VACCINE 2019-2020 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
/ /	Sanofi Pasteur	UJ231AB	0.5 ml		L R	<input type="checkbox"/> IM single dose	August 2019
	MedImmune	LJ2229	0.2 ml		Deltoid	<input type="checkbox"/> Nasal	State Supplied No