School Year: 20-21

NPI: 1245236306

School Name:

INFLUENZA VACCINE
HEALTH SCREEN & PERMISSION FORM

Full Name:		Date of Birth: / /	Age:	Gender: ☐ M ☐ F ☐O	
Street Address:		Town/City:		Zip Code:	Daytime Phone:
Grade:	Teacher:			School Administrative Unit (District)	

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: _____
Doctor's Name:_____ Phone Number:_____

Please answer the following questions about <u>the person named above</u>. 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		
4) Does this person have asthma; currently wheezing; have a history of wheezing if under 5 years old; have problems with their heart, kidneys, lungs; diabetes; or are pregnant or nursing?		
5) Does this person regularly use aspirin or a medication with an aspirin-containing medication? (Children or adolescents should not be given aspirin for 4 weeks after getting FluMist.)		
6) Does this person have a weakened immune system, or come in close contact with someone who has a severely weakened immune system?		
7) Has this person received Tamiflu, Relenza, amantadine, or rimantadine within the past 48 hours?		
8) Has this person received any other vaccinations in the past 4 weeks? If yes: Type_____ Date_____		
If you answered "yes" to any questions 4-7, this person cannot receive the intranasal flu vaccine		

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 Maine Immunization Information System, ImmPact.
- ☐ I give permission for information to be used to bill MaineCare or private insurance for the cost of providing the vaccine.
- ☐ **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
VACCINE TYPE PREFERRED: Shot only ☐ Mist only ☐ (if not available child will not be vaccinated) Nurse decides ☐

FOR OFFICE USE ONLY:

Date Dose Administered	Vaccine Manufacturer	Lot Number	Dose Volume	Signature and Title of Vaccinator	Body Site	Route	VIS date
/ /						▢ IM single dose ▢ IM multi vial	08/2019 State Supplied

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