INFLUENZA VACCINE 2014-2015 HEALTH SCREEN & PERMISSION FORM

NPI:
School Name: _____

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

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 flu vaccination		
4) Has this person received any other vaccinations in the past 4 weeks, or is not feeling well? If yes, Type of vaccine_____ Date_____		
5) Does this person have long-term health problems, allergies, asthma or wheezing problems, or on long-term aspirin treatment?		
6) Does this person have a weakened immune system, or come in close contact with someone who has a severely weakened immune system? Explain: _____		
7) Is this person pregnant or could this person be pregnant?		
If you answered "yes" to any questions 4-7, this person <u>cannot receive the intranasal</u> flu vaccine		
8) Is this person an American Indian or an Alaskan Native?		
9) Is this person uninsured?		
10) Is this person insured by MaineCare (Medicaid)? MaineCare ID #:_____		

11) Health Insurance: Name of Company: _____

ID Number: _____ Group number: _____

Subscriber Name_____ Subscriber Date of Birth _____

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

PERMISSION TO VACCINATE

- I was given a copy of the 2014-2015 Influenza Vaccine Information Statements, I have read them or had them 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 clinic health care staff.
- If my child refuses to receive the injection and does not have any of the conditions #4-7 listed above, you have my permission to give the nasal flu mist.
- **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/Guardian or Adult to be Vaccinated_____

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 dose ☐ Intranasal	