

INFLUENZA VACCINE 2022-2023 HEALTH SCREEN & PERMISSION FORM

NPI:1649213125

DEPT Name:

*Full Name:		*Date of Birth: / /	Age:	*Gender:
*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: _____

Please answer the following questions about the person named at top of form. 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 been diagnosed with Guillain-Barre Syndrome?		
4) Has this person received a pneumonia or tetanus/diphtheria vaccine in the last 30 days?		
5) (nasal flu) Does this person have asthma or wheezing issues?		

If you answered "yes" to any questions 1-4, please see your healthcare provider for influenza vaccination

PERMISSION TO VACCINATE

- I was offered 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.**

Printed Name of Parent/Guardian or Adult: _____

X _____ Date: _____
Signature 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
/ /			0.5 cc		LA	<input type="checkbox"/> IM single dose <input type="checkbox"/> IM multi vial <input type="checkbox"/> Nasal	8/6/2021
					RA		State Supplied Y N