**INFLUENZA VACCINE 2017-2018**

School:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI: 1033447560

**HEALTH SCREEN & PERMISSION FORM**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| DATE | VACCINEMANUFACTURER | LOTNUMBER | DOSEVOLUME | SIGNATURE AND TITLE OF VACCINATOR | BODYSITE | ROUTE | VISDATE |
|  |  |  | 0.5ML |  | Deltoid | IM single dose | 8/7/2015 |

 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#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FOR PRIVATE INSURANCE**:

Name of Insurance Company:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID Number:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber’s Name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Check if MEA Benefits Trust

School Administrative Unit:

 RSU #10

Teacher:

Grade:

Phone:

Zip Code:

Town:

Street Address:

Gender:

\_\_\_M \_\_\_F

Age:

DOB:

Full Name:

**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 my student 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/Guardian or Signature of adult to be vaccinated

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

 FOR OFFICE USE ONLY:

1. Does this person have a severe (life-threatening) allergy to eggs? \_\_\_yes \_\_\_no
2. Has this person ever had a severe reaction to an influenza immunization in the past? \_\_\_yes \_\_\_no
3. Has this person ever had Guillain-Barre Syndrome? \_\_\_yes \_\_\_no

 **If you answered “yes” to any questions 1-3, please see your healthcare provider for the influenza vaccine.**

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