INFLUENZA VACCINE
HEALTH SCREEN & PERMISSION FORM

School Year:

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)	

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 <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 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**
/ /						□ IM single dose □ IM multi vial	State Supplied Y N