MENINGOCOCCAL (MenACWY) VACCINE
2018-2019 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)

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) Has this person ever had a severe allergic reaction to a vaccine component or following a prior dose of MenACWY vaccine in the past?		
2) Does this person have a moderate or severe acute illness?		
3) Has this person ever had Guillain-Barre Syndrome?		

If you answered "yes" to any questions 1-3, please see your healthcare provider for MenACWY vaccination

PERMISSION TO VACCINATE

- I was given a copy of the Meningococcal (MenACWY) 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 MenACWY 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	State Supplied Y N