

TETANUS, DIPHTHERIA, PERTUSSIS (TDAP) VACCINE 2018-2019 HEALTH SCREEN & PERMISSION FORM

NPI:

School Name:

Full Name:		Date of Birth: / /	Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> 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 the person named above. Comments may be written on the back of this form.

	<u>YES</u>	<u>NO</u>
1) Has this person ever had a severe allergic reaction following a prior dose of vaccine in the past?		
2) Has this person ever had encephalopathy within 7 days following a prior dose of vaccine 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 Tdap vaccination

PERMISSION TO VACCINATE

- I was given a copy of the Tetanus, Diphtheria, Pertussis (Tdap) 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 Tdap 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
/ /						<input type="checkbox"/> IM single dose	State Supplied Y N