**{School Name}
PERMISSION TO VACCINATE**

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| Full Name: | Date of Birth: | Age: | Sex: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 noIs this person uninsured? yes noIs this person insured by MaineCare (Medicaid)? yes noMaineCare ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Private Insurance? yes noName of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Subscriber Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

* I was given a copy of the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Vaccine Information Sheet, I have read this or had this explained to me and I understand the benefits and risks of the 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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**:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **FOR OFFICE USE ONLY:**  | **Vaccine Manufacturer** | **Lot Number** | **Dose Volume** | **Signature and Title of Vaccinator** | **Body Site** | **Route** | **VIS date** |
|  |  |  |  |  |  |  |  |
| **Date Dose Administered:** | □ IM single dose □ SC single dose□ IM multi vial □ SC multi vial □ Intranasal |
| State Supplied Vaccine □ Yes □ No |