**{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 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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  * 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 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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 | | | | | | | |