<SCHOOL NAME> **<SCHOOL YEAR>** **NPI: _____**

CHILD VACCINE HEALTH SCREEN & CONSENT FORM

Please answer the following questions about the person to be vaccinated.

Name:	Date of Birth:	Age:	Grade in School:	Preferred Language:

Vaccine Eligibility & Insurance:	Check all that apply	Gender:
☐ Insured, State Eligible <19yrs ☐ No Health Insurance ☐ Medicaid/MaineCare ID #_____	☐ Native American/Alaska Native ☐ Underinsured ☐ Private Insurance Company Name _____ ID #_____ Group # _____	☐ Male ☐ Female ☐Non-Binary/X ☐Transgender ☐Prefer not to disclose ☐Other _____

Race:		Ethnicity:
☐American Indian or Alaska Native	☐Black or African American	☐Hispanic/Latino
☐Asian	☐White	☐Non-Hispanic/Non-Latino
☐Native Hawaiian or Other Pacific Islander	☐Other Race	

Street Address:	City/Zip:	Daytime Phone:

Please answer the following questions about the person named above.	**Yes**	**No**	**Don't Know**
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Does the child have a long-term health problem with lung, heart, kidney or metabolic disease (e.g. diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
6. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
7. Does the child have a parent, brother, or sister with an immune system problem?	☐	☐	☐
8. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
9. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
10. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
11. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

The above-named child is due for, and will receive, the following vaccine(s):	
☐ **Please check my child's records and administer any vaccine(s) he/she needs**	
☐ COVID-19	☐ Meningococcal Conjugate (MenACWY)
☐ DTap/Tdap (diptheria, tetanus, acellular pertussis)	☐ MMR (Measles, Mumps, and Rubella)
☐ Flu (influenza)	☐ PCV13 (Pneumococcal Conjugate)
☐ Hep A (hepatitis A)	☐ Polio
☐ Hep B (hepatitis B)	☐ PPSV23 (Pneumococcal Polysaccharide)
☐ Hib (Haemophilus influenzae type b)	☐ Rotavirus
☐ Human Papillomavirus Vaccine (HPV)	☐ Varicella (Chicken Pox)
☐ Meningococcal B	☐ Other: _____

Did you bring your child's vaccination record with you? ☐ Yes ☐ No

If yes, please provide it to the person reviewing this form. You will be provided a record of the vaccinations received today.

Please turn over and complete other side ⇨

<SCHOOL NAME> **<SCHOOL YEAR>** **NPI: _____**

CHILD VACCINE HEALTH SCREEN & CONSENT FORM

Please answer the following questions about the person to be vaccinated.

PLEASE CHECK ONE OF THE FOLLOWING BOXES:

☐ My child's immunizations **can be done without** my presence.

☐ My child's immunizations **can only be done with** my presence.

CONSENT TO VACCINATE

- I have been offered a copy of the Vaccine Information Statement(s) (VIS) above. I have read, had explained to me, and understand the information in the VIS(s).
- I understand that a record of this vaccination will be entered into the Maine Immunization Information System, ImmPact.
- I understand that the individual receiving immunization is advised to stay on site today for at least 15 minutes post-vaccination.
- 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(s) indicated above to be given to me or to the person named above for whom I am authorized to make this request.

▶ _____Date:_____ Relationship to Child _____

Signature of Parent or Legal Guardian

▶ _____Date:_____

Signature of interpreter

FOR CLINICAL USE ONLY

Documentation Information		
Clinic Site:	District:	Administrator Name:
Patient Name:	Patient DOB:	

Vaccine	Dose	Extremity	Site	Route	VIS Date	Manufacturer & Lot #	Expiration Date
COVID-19	Pfizer: 0.3mL Moderna: 0.5mL	Right Left	Deltoid Vastus Lateralis	IM			
DTap/Tdap	0.5 mL	Right Left	Deltoid Vastus Lateralis	IM			
Haemophilus influenzae type b (Hib)	0.5mL	Right Left	Deltoid Vastus Lateralis	IM			
Hepatitis A (HepA)	0.5mL	Right Left	Deltoid Vastus Lateralis	IM			
Hepatitis B (HepB)	0.5mL	Right Left	Deltoid Vastus Lateralis	IM			
Human papillomavirus (HPV)	0.5mL	Right Left	Deltoid Vastus Lateralis	IM			
Flu, inactivated (IIV)	0.25 mL 0.5mL	Right Left	Forearm Deltoid Vastus Lateralis	IM			
Flu, (live attenuated) (LAIV4)	0.2mL (0.1mL per nostril)	Left nare Right nare	Bilateral Nares	Intranasal Spray			
Measles, mumps, rubella (MMR)	0.5 mL	Right Left	Posterior tricep Vastus Lateralis	SC			
Meningococcal serogroups ACWY (MenACWY)	0.5mL	Right Left	Deltoid Vastus Lateralis	IM			
Meningococcal B (MenB)	0.5 mL	Right Left	Deltoid Vastus Lateralis	IM			
Pneumococcal 13-valent conjugate (PCV13)	0.5mL	Right Left	Deltoid Vastus Lateralis	IM			
Pneumococcal 23-valent polysaccharide (PPSV23)	0.5 mL	Right Left	Deltoid Posterior tricep Vastus Lateralis	IM SC			
Polio (IPV)	0.5 mL	Right Left	Deltoid Posterior tricep Vastus Lateralis	IM SC			
Rotavirus (RV1) (RV5)	Rotarix 1.0mL Rotateq 2.0mL	By mouth	Mouth	Oral			
Varicella (VAR)	0.5mL	Right Left	Upper Arm Vastus Lateralis	SC			

State-Supplied Vaccine ☐ Yes ☐ No

X_____ _____

Signature and Credentials of Vaccine Administrator Date