

# INFLUENZA VACCINE 2015-2016 HEALTH SCREEN & PERMISSION FORM

NPI: 1245236306

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)	

Please answer the following questions about the person named above. Comments may be written on the back of this form.

	YES	NO
1) Does this person have a severe (life-threatening) allergy to eggs?		
2) Has this person ever had a severe reaction to an influenza immunization in the past?		
3) Has this person ever had Guillain-Barre Syndrome?		
<b>If you answered "yes" to any questions 1-3, please see your healthcare provider for flu vaccination</b>		
4) Has this person received any other vaccinations in the past 4 weeks, or is not feeling well? If yes, Type of vaccine _____ Date _____		
5) Does this person have long-term health problems, allergies, asthma or wheezing problems, or on long-term aspirin treatment?		
6) Does this person have a weakened immune system, or come in close contact with someone who has a severely weakened immune system? Explain: _____		
7) Is this person pregnant or could this person be pregnant?		
<b>If you answered "yes" to any questions 4-7, this person cannot receive the intranasal flu vaccine</b>		
8) Is this person an American Indian or an Alaskan Native?		
9) Is this person uninsured?		
10) Is this person insured by MaineCare (Medicaid)? MaineCare ID #: _____		

11) Health Insurance: Name of Company: \_\_\_\_\_  
 ID Number: \_\_\_\_\_ Group number: \_\_\_\_\_  
 Subscriber Name \_\_\_\_\_ Subscriber Date of Birth \_\_\_\_\_

12) Doctor's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## PERMISSION TO VACCINATE

- I was given a copy of the 2015-2016 Influenza Vaccine Information Statements, I have read them or had them 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 ImmPact Registry.
- I give permission for information to be used to bill MaineCare or private insurance for the cost of providing the vaccine
- I give my consent for this person to receive the most appropriate vaccine, as determined by the clinic health care staff.
- If my child refuses to receive the injection and does not have any of the conditions #4-7 listed above, you have my permission to give the nasal flu mist.
- **I give permission for the flu 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/Guardian or Adult to be Vaccinated \_\_\_\_\_

### 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 <input type="checkbox"/> IM multi dose <input type="checkbox"/> Intranasal	