NPI: 1033447560

School: _____

INFLUENZA VACCINE 2017-2018
HEALTH SCREEN & PERMISSION FORM

Full Name:	DOB:	Age:	Gender: ___M ___F
Street Address:	Town:	Zip Code:	Phone:
Grade:	Teacher:	School Administrative Unit: RSU #10	

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#: _____

Primary Care Provider: _____

Phone number: _____

FOR PRIVATE INSURANCE:
Name of Insurance Company:
_____
ID Number:
_____
Group Number:
_____
Subscriber's Name:
_____
☐ Check if MEA Benefits Trust

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

1. Does this person have a severe (life-threatening) allergy to eggs? ___yes ___no
2. Has this person ever had a severe reaction to an influenza immunization in the past? ___yes ___no
3. Has this person ever had Guillain-Barre Syndrome? ___yes ___no

If you answered "yes" to any questions 1-3, please see your healthcare provider for the influenza vaccine.

PERMISSION TO VACCINATE

- I was given a copy of the influenza (Flu) 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 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 my student to receive the most appropriate vaccine, as determined by the health care clinic staff.
- **I give permission for the flu vaccine to be given to the person named above by signing below.**

X_____ Date: _____
Signature of Parent/Guardian or Signature of adult to be vaccinated

Printed Name of Parent or Guardian: _____

FOR OFFICE USE

DATE	VACCINE MANUFACTURER	LOT NUMBER	DOSE VOLUME	SIGNATURE AND TITLE OF VACCINATOR	BODY SITE	ROUTE	VIS DATE
			0.5ML		Deltoid	IM single dose	8/7/2015