

# INFLUENZA VACCINE 2016-2017 HEALTH SCREEN & PERMISSION FORM

NPI:1083820906

School Name:  
conners-emerson

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) AOS 91	

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: \_\_\_\_\_

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?		

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

## 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 this person 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 or guardian if person to be vaccinated is a minor or Signature of adult to be vaccinated

Printed Name of Parent or Guardian: \_\_\_\_\_

### FOR OFFICE USE ONLY:

Date Dose Administered	Vaccine Manufacturer	Lot Number	Dose Volume	Signature and Title of Vaccinator	Body Site	Route	VIS date
/ /	GlaxoSmithKline	9D325	0.5ml			<input checked="" type="checkbox"/> IM single dose <input type="checkbox"/> IM multi vial	State Supplied <input checked="" type="checkbox"/> Y <input type="checkbox"/> N