INFLUENZA VACCINE HEALTH SCREEN & PERMISSION FORM | **School Year: 20-21** | **NPI: 1245236306**

Full Name:	Date of Birth: / /	Age:	Gender: M F O	**School Name:**
Street Address:	Town/City:		Zip Code:	Daytime Phone:
Grade:	Teacher:		School Administrative Unit (District) Sanford School Department	

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: _____

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		
4) Does this person have asthma; currently wheezing; have a history of wheezing if under 5 years old; have problems with their heart, kidneys, lungs; diabetes; or are pregnant or nursing?		
5) Does this person regularly use aspirin or a medication with an aspirin-containing medication? (Children or adolescents should not be given aspirin for 4 weeks after getting FluMist.)		
6) Does this person have a weakened immune system, or come in close contact with someone who has a severely weakened immune system?		
7) Has this person received Tamiflu, Relenza, amantadine, or rimantadine within the past 48 hours?		
8) Has this person received any other vaccinations in the past 4 weeks? If yes: Type_____ Date_____		
If you answered "yes" to any questions 4-7, this person cannot receive the intranasal flu 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 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 flu vaccine to be given to the person named above by signing below.**

X_____ Date:_____

Signature of parent or guardian

VACCINE TYPE PREFERRED: Shot only Mist only (if not available child will not be vaccinated) Nurse decides

FOR OFFICE USE ONLY:

Date Dose Administered	Vaccine Manufacturer	Lot Number	Dose Volume	Signature and Title of Vaccinator	Body Site	Route	VIS date
/ /						□ IM single dose □ IM multi vial	State Supplied Y N