HEALTH SCREEN & PERMISSION FORM – Influenza Vaccine

(rev. 9/8/2010)

Please answer the following questions about the person to be vaccinated. This will tell us who can receive the influenza vaccination in the school clinic setting.

Name:	Birthdate:	Age:
Street:	City:	Phone:
Grade:	Teacher:	

	YES	NO
1) Does this person have an allergy to eggs, chicken, gentamicin, gelatin, or arginine?		
2) Has this person ever had a serious reaction to immunizations in the past?		
3) Has this person ever had Guillain-Barre Syndrome?		
If you answered "yes" to any of the above questions, this person cannot receive flu vaccine at the scheduled school clinic. Please contact your health care provider instead.		
4) Does this person have asthma, diabetes, lung disease, heart disease, kidney problems, a blood disorder, immunodeficiency disease, or take aspirin or immunosuppressive therapies?		
5) Has this person received any other vaccinations in the past 4 weeks? Include date and type of vaccinations received: _____		
6) Does this person have a weakened immune system or come in close contact with someone who has a weak immune system (for example, HIV, cancer) or is this person taking medications such as steroids or those used to treat cancer?		
7) Could this person be pregnant or nursing?		
8) Is this person insured by MaineCare (Medicaid)?		
9) Is this person an American Indian or an Alaskan Native?		
10) Is this person under-insured (has insurance that does not cover flu vaccine)?		
11) Is this person uninsured?		

12a) Health care provider:	12b) Healthcare provider phone number:
13) Health Insurance Company (if any) and ID Number:	

	YES	NO
14) I give permission for a record of this vaccination to be used to bill either MaineCare or private insurance for the cost of providing the vaccine and agree to allow this information to be entered into the ImmPact2 registry which will be available to primary care providers.		

15) I was given a copy of the 2010 Influenza Vaccine Information Statement and I have read it or had it explained to me. I understand the benefits and risks of the 2010 Influenza Vaccination **and ask that the vaccine be given to this person.** I understand that if I sign below, I am giving my consent either on behalf of myself, my child/ward, or both, to receive the most appropriate vaccine, as determined by the health care provider giving the vaccination.

X_____

Signature of person to be vaccinated or signature of parent or guardian if person to be vaccinated is a minor

Parent or Guardian Name (please print):_____ Date:_____

FOR OFFICE USE ONLY:

Date Dose Administered	Vaccine	Vaccine Manufacturer	Lot Number	Dose Volume	Signature and Title of School Vaccine Provider	Body Site	Route
/ /							□ IM □ Intranasal