NPI:1649213125

INFLUENZA VACCINE 2020-2021
HEALTH SCREEN & PERMISSION FORM

School Name: CDS and Dedham

*Full Name:	*Date of Birth: / /	Age:	*Gender:	
*Street Address:	*Town/City:		*Zip Code:	Daytime Phone:
Grade:	Teacher:		School Administrative Unit (District) CDS and Dedham schools	

*Required

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 <u>the person named above</u>. 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 been diagnosed with Guillain-Barre Syndrome?		
4) **(nasal flu)** Does this person have asthma or wheezing issues?		

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.**

Printed Name of Parent/Guardian or Adult:_____

X_____Date:_____

Signature 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
/ /			0.5 cc		LA RA	□ IM single dose □ IM multi vial □ Nasal	8/15/2019 State Supplied Y N

UMMS Provider Code: 116737176