School Name: ______________

2021-2022

MAINEGENERAL HEALTH
HEALTH SCREEN & PERMISSION FORM
COVID-19 SCHOOL IMMUNIZATION

Name:	Date of Birth:	Age:	Gender: ☐ M ☐ F
Street Address: ______________ City, State: ______________ Zip Code: ________			Phone:
Race: ☐ American Indian ☐ Alaskan Native ☐ Native Hawaiian or Other Pacific Islander	☐ Black or African American ☐ White ☐ Other Race: ______________		Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino
School Administrative Unit (District):	Teacher:		Grade:

Please answer the following questions about ***the person named above*** *for the COVID-19 Vaccine.*	Yes	No
Has this person ever received a dose of COVID-19 vaccine? If yes, date administered: ______________ *If yes, Pfizer* ☐ *Moderna* ☐ *Other* ☐ ______________	☐	☐
1. Is this person feeling sick today?	☐	☐
2. Has this person ever had an allergic reaction to: (This would include a severe allergic reaction (e.g. anaphylaxis) that required treatment with epinephrine or EpiPen or that caused this person to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)		
a. A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures.	☐	☐
b. Polysorbate	☐	☐
c. A previous dose of COVID-19 vaccine	☐	☐
3. Has this person ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction (e.g. anaphylaxis) that required treatment with epinephrine or EpiPen or that caused this person to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)	☐	☐
4. Has this person ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.	☐	☐
5. Has this person ever received any other vaccines in the last 14 days?	☐	☐
6. Has this person ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?	☐	☐
7. Has this person received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	☐	☐
8. Does this person have a weakened immune system caused by something such as HIV infection or cancer, or do you take immunosuppressive drugs or therapies?	☐	☐
9. Does this person have a bleeding disorder or is this person taking a blood thinner?	☐	☐
10. Is this person pregnant or breastfeeding?	☐	☐

PERMISSION TO VACCINATE

- I have been provided the Emergency Use Authorization Fact Sheet, as applicable, and I understand the benefits and risks of the COVID-19 vaccination.
- I give permission for a record of this vaccination to be entered into the Maine Immunization Information System, ImmPact.
- I give my consent for this person to receive the most appropriate vaccine, as determined by the health care clinic staff.
- I understand that I am advised to stay on site today for 15 or 30 minutes post-vaccination. If I refuse to stay, I assume full responsibility for any adverse consequences that arise from my leaving including a potential severe allergic reaction to the vaccine that may hinder my ability to breathe and may require emergency care.
- **I give permission for the COVID-19 vaccine to be given to the person named above by signing below.**

X______________________________ Date:__________

Signature of guardian of person to be vaccinated or Signature of adult to be vaccinated

Printed Name of Parent or Guardian:

FOR OFFICE USE ONLY:

Date Dose Administered	Vaccine Manufacturer & Lot Number	Vial Expiration Date	Dose Volume	Signature and Credentials of Vaccine Provider	Injection Site	Route	EUA date
Dose #1: / /					L. Deltoid R. Deltoid	☐IM	
Dose #2: / /					L. Deltoid R. Deltoid	☐IM	

October 2021