

School Name: \_\_\_\_\_

2022-2023

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

Name: _____	Date of Birth: _____	Age: _____	Birth Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other Gender Identity: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other
Street Address: _____		Phone: _____	
City, State: _____		Zip Code: _____	
Race: <input type="checkbox"/> American Indian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> 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: _____ <i>If yes, Pfizer <input type="checkbox"/> Moderna <input type="checkbox"/> Other <input type="checkbox"/> _____</i>	<input type="checkbox"/>	<input type="checkbox"/>
1. Is this person feeling sick today?	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
b. Polysorbate	<input type="checkbox"/>	<input type="checkbox"/>
c. A previous dose of COVID-19 vaccine	<input type="checkbox"/>	<input type="checkbox"/>
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.)	<input type="checkbox"/>	<input type="checkbox"/>
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.)	<input type="checkbox"/>	<input type="checkbox"/>
5. Has this person tested positive for COVID-19 in the last 14 days?	<input type="checkbox"/>	<input type="checkbox"/>
6. Has this person received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
7. Does this person have a weakened immune system caused by something such as HIV infection or cancer, or does this person take immunosuppressive drugs or therapies?	<input type="checkbox"/>	<input type="checkbox"/>
9. Does this person have a bleeding disorder or is this person taking a blood thinner?	<input type="checkbox"/>	<input type="checkbox"/>
10. Does this person have a history of multisystem inflammatory syndrome; either MIS-C (children) or MIS-A (adults)?	<input type="checkbox"/>	<input type="checkbox"/>
11. Does this person have a history of myocarditis or pericarditis?	<input type="checkbox"/>	<input type="checkbox"/>
12. Does this person have a history of Guillain-Barre-Syndrome (GBS)?	<input type="checkbox"/>	<input type="checkbox"/>
13. Does this person have a history of an immune mediated syndrome like heparin-induced thrombocytopenia (HIT) or history of thrombosis with thrombocytopenia (TTS)?	<input type="checkbox"/>	<input type="checkbox"/>

**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	<input type="checkbox"/> IM	
Dose #2: / /					L. Deltoid R. Deltoid	<input type="checkbox"/> IM	
Circle One: Booster: / /					L. Deltoid R. Deltoid	<input type="checkbox"/> IM	
Additional Dose: / /							

If Additional Dose: Patient Self-Reported Qualifying Condition: \_\_\_\_\_