

H1N1 Nasal spray vaccine

Healthy 2 – 49 years of Age only

NORTH ATTLEBORO BOARD OF HEALTH Date _____

Adult/child's name _____ Address _____

Please print

City/state/zip _____ DOB _____ age _____

Phone _____

Has adult/child had a previous Flu shot? Yes _____ when _____ Type _____
Shot _____ Nasal spray _____ No _____

Has the adult/child ever had a serious reaction to a flu shot in the past? yes _____ no _____

Is the adult/child sick today? yes _____ no _____

Does adult/child have chronic illness yes _____ no _____

Does adult/child have an allergy to eggs? yes _____ no _____

Is the adult/child pregnant yes _____ no _____

Has adult/child ever had Guillain-Barré Syndrome? yes _____ no _____ don't know _____

Does adult/child have an allergy to Latex? yes _____ no _____

I have read and received the vaccine information statement (VIS) explaining the benefits and risks of the influenza vaccine and have had my questions answered. I realize that this vaccine may contain thimerosal (preservative).

I, _____ give the North Attleboro Board of Health permission
Patient, parent, legal guardian
to administer the flu vaccine to my child / self.

_____ I/my child has infant/high risk in home; are a health care worker/first responder.

_____ I/my child are considered "high risk" and have one of the following: diabetes; metabolic disease; disease of the lungs, heart, kidneys, liver, nerve, or blood; or long-term aspirin or aspirin containing therapy; have a weak immune system; pregnant.

_____ I want to be protected from the flu

_____ I want my child to be protected from the flu

Flu Mist vaccine only:

Does child have a history of reoccurring wheezing and is 24 – 59 months of age? yes _____ no _____

Does child/adult have asthma? Yes _____ No _____

For Clinic / Office use:

Vaccine name: Influenza A H1N1 Date vaccine administered: _____

Injection site: _____ Date VIS given: _____ Date on VIS: 10/2/09

Vaccine Manufacturer: _____ Vaccine lot number _____ Exp. _____

Name and title of vaccine administrator: North Attleboro Board of Health

Clinic/office address: 43 South Washington St., North Attleboro, MA Administrator's initials _____

Children 2 – 9 only Dose #1 _____ Dose #2 _____ (at least 1 month after 1st dose)