

H1N1 FLU VACCINE

6 months of age & older

NORTH ATTLEBORO BOARD OF HEALTH Date _____

Name _____ Address _____

Please print

City/state/zip _____ Phone # _____ age _____

Has adult/child had a previous Flu shot? yes _____ when _____ type _____
no _____

Have you ever had a serious reaction to flu shot in the past? yes _____ no _____ don't know _____

Are you sick today? yes _____ no _____ don't know _____

Do you have an allergy to eggs? yes _____ no _____ don't know _____

Have you ever had Guillain-Barré Syndrome? yes _____ no _____ don't know _____

Do you 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, _____ give the North Attleboro Board of Health

Signature (patient, parent or legal guardian)

permission to administer the flu vaccine.

_____ I certify that I belong to one of the following "HIGH RISK" category.

- pregnant
- Infant / high risk in home
- Health care worker / first responder
- Chronic medical condition

_____ I want to be protected from the flu

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 _____

Dose #1 _____ Dose #2 _____ at least 1 month after 1st dose