

Seasonal Flu Shot

6 months and older

FLU VACCINE

NORTH ATTLEBORO BOARD OF HEALTH Date _____

Name _____ Address _____

Please print

City/state/zip _____ age _____

Have you had a previous Flu shot? yes _____ no _____

Have you ever had a serious reaction to flu shot in the past? yes _____ no _____

Are you sick today? yes _____ no _____

Do you have an allergy to eggs? yes _____ no _____

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.

- Chronic medical condition
- Age 50 and older
- Pregnant
- Health care worker / first responder
- Infant / high risk in home

_____ I want to be protected from the flu

For Clinic / Office use:

Vaccine name: Fluzone Date vaccine administered: _____

Injection site: _____ Date VIS given: _____ Date on VIS: 8/11/09

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 _____