

Seasonal Nasal Spray

Healthy 2 – 49 years of Age

FLU MIST VACCINE

NORTH ATTLEBORO BOARD OF HEALTH Date _____

Adult/child's name _____ Address _____
Please print

City/state/zip _____ dob _____ age _____

Has adult/child had a previous Flu shot? Yes _____ when _____ 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 an allergy to eggs? 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
Self / Parent signature
to administer the flu vaccine to my child / self.

_____ 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: _____ FluMist _____ 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 _____

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