

4 – 17 years of Age

FLU VACCINE

NORTH ATTLEBORO Public Schools Date _____

Child's name _____ Address _____
Please print

City/state/zip _____ dob _____ age _____

Grade _____ Homeroom _____

Has child had a previous Flu shot? Yes _____ when _____ no _____

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

Is the child sick today? yes _____ no _____

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

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

Does 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 Public Schools permission
Parent signature
to administer the flu vaccine to my child.

_____ I certify that my child belongs to one of the following "HIGH RISK" category.

- 6 months to 5 years of age
- Chronic medical condition
- Pregnant
- Health care worker / first responder
- Infant / high risk in home

_____ I want my child to be protected from the flu

For Clinic / Office use:

Vaccine name: Fluzone Date vaccine administered: _____

Injection site: _____ Date VIS given: _____ Date on VIS: _____

Vaccine Manufacturer: Sanofi Pasteur Vaccine lot number UH471AA Exp6/30/12

Name and title of vaccine administrator: _____

Clinic/office address: 6 Morse St North Attleboro Ma 02760 Administrator's initials _____