

# 4 – 17 years of Age

## FLU MIST 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 immunization? Yes \_\_\_\_\_ when \_\_\_\_\_ no \_\_\_\_\_

Has the child ever had a serious reaction to a flu immunization 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, \_\_\_\_\_ give the North Attleboro School Department 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: Flumist Date vaccine administered: \_\_\_\_\_

Date VIS given: \_\_\_\_\_ Date on VIS: \_\_\_\_\_

Vaccine Manufacturer: Medimmune Vaccine lot number YK2014 Exp 1/8 /12

Name and title of vaccine administer: \_\_\_\_\_ School Nurse

Clinic/office address: North Attleboro School Department Administrator's initials \_\_\_\_\_