3 Years or Older

NORTH ATTLEBORO Public Schools 2020-2021 FLU VACCINE

Date ______________________________

Name ___________________________________ DOB___________________________-

Address ____ North Attleboro, MA 02760

School_________________________________ Grade/Homeroom _____________________________

Have you/your child had a previous flu vaccine? yes_________ no__________

If Yes, date of vaccination: ___________________________

Have you/your child ever had a serious reaction to a flu shot in the past? yes_______ no _______

If Yes, what happened? ____

Are you/your child sick today*?* *yes* _________ *no* __________

Do you/your child have an allergy to eggs? yes __________no __________

Do you/your child have an allergy to Latex? yes _________ no __________

Have you/your child ever had Guillain-Barré Syndrome? yes _______ no ___________ don't know ______

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 Public School Nurses administer the flu vaccine to me/my child.
Parent signature

For Clinic / Office use:

Vaccine name: FLULAVAL QUADRIVALENT___ Date vaccine administered: ___________________________

Injection site: ____________________________ Date VIS given: _________________ Date on VIS: 8/15/2019

Vaccine Manufacturer: GlaxoSmithKline Vaccine lot number: 275KY Exp: 6/30/2021

Clinic/office address: North Attleboro Public Schools, 564 Landry Ave, North Attleboro, MA____________

Name and title of vaccine administrator: ____