

# Injectable FLU VACCINE

FLU VACCINE 2025-2026

NORTH ATTLEBORO HEALTH DEPARTMENT

Date \_\_\_\_\_

Name \_\_\_\_\_ age \_\_\_\_\_

Please print

Have **you**/your child had a previous Flu shot? yes \_\_\_\_\_ When? \_\_\_\_\_ no \_\_\_\_\_

Have **you**/your child ever had a serious reaction to 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 \_\_\_\_\_

Have **you**/your child ever had Guillain-Barré Syndrome? yes \_\_\_\_\_ no \_\_\_\_\_ don't know \_\_\_\_\_

Do **you**/your 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.

**PLEASE FILL OUT OTHER  
SIDE OF THIS FORM  
(print clearly)**

**ATTACH A COPY OF  
YOUR INSURANCE CARD  
or FILL OUT ALL THE  
INSURANCE INFO**

