

FLU VACCINE FORM

(Please fill out top of form and bring to your appointment.)

Date: _____

Patient name: _____

DOB: _____

Egg allergy? Yes ___ No ___

Active Wheezing? Yes ___ No ___

Prolonged Aspirin Therapy? Yes ___ No ___

H/O Guillain-Barre syndrome? Yes ___ No ___
(a severe paralytic illness also called GBS)

Signature of Parent/Guardian _____

FLU SHOT

6-35mo. _____ Lot# _____ Exp. Date _____ Site _____

3+years _____ Lot# _____ Exp. Date _____ Site _____

FLU MIST

2 years of age Lot# _____ Exp. Date _____

Administrator initials: _____

V.I.S. FORM GIVEN _____