

## Naugatuck Valley Health District Influenza Vaccine Consent Form (2025-26)

## Please **Print** Clearly

Last Name					First Name					M.
Street A	Address					Town			State	Zip Code
hone ‡	‡		Date of Birth (	Month/Day/Year)	Age	Gender	Email			
Yes	No	1. Are you	sick today?							
Yes	No	2. Have you	2. Have you ever had a serious reaction to the flu shot?							
Yes	No	3. Any aller	gies to eggs	s, thimerosal, c	or other	compon	ents of th	e vaccine?		
Yes	No	4. Have you	ı ever had (	Guillain-Barre s	yndrom	e?				
lease	Answer	the Followin	g Question	s:						
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