Chelmsford Pediatrics
Grow with us!
Affiliated with Dracut Pediatrics
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2025-2026 Influenza Vaccination Form

Patient Full Name:_____

Patient DOB:_____

Patient #:_____

Guardian #:_____

Has the patient received a flu vaccine in the past?

☐ YES

☐ NO

Has your child ever had a severe, immediate allergic reaction / anaphylaxis to any medication, vaccine, or injection before?

☐ YES

If yes, please explain:_____

_____

☐ NO

Has your child ever had Guillain-Barre syndrome?

☐ YES

☐ NO

☐ Don't know

Insurance: please list the patients insurance

Patient Signature:_____Date:_____

Patient Name:_____Date:_____

Guardian Signature:_____ Date:_____

Guardian Name:_____Date:_____