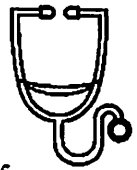




New Haven Public Schools  
 School-Based Health Centers  
 Mauro-Sheridan Interdistrict Magnet



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 New Haven, CT 06515  
 Brian Forsyth, M.D., Medical Director

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 FAX: 203-946-7088  
 Earlene Peckham, APRN, Nurse Practitioner/Manager  
 Betsy Kunz LCSW SBHC social Worker

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*Career High SBHC*  
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 Tel:

*James Hillhouse SBHC*  
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 New Haven, CT 06511  
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*Roberto Clemente SBHC*  
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*Fair Haven Middle SBHC*  
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*Jackie Robinson SBHC*  
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*Sheridan Academy SBHC*  
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*Vincent Mauro SBHC*  
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*Truman SBHC*  
 114 Truman St.  
 New Haven, CT  
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*Davis Street SBHC*  
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*Administrative Offices*  
 54 Meadow Street  
 Gateway Bldg. 3<sup>rd</sup> flr  
 New Haven, CT 06519

**Seasonal Flu Vaccine 2015-2016**

**Parents:** In order for your child to receive the flu shot at the School Based Clinic, your child must be a member of the clinic. You will need to complete this form below for the flu shot and return it to the clinic.

Name of Student: \_\_\_\_\_ Phone \_\_\_\_\_  
 Date of birth: \_\_\_\_\_ Grade \_\_\_\_\_ insurance \_\_\_\_\_

Please answer the following questions, **circle** yes or no.

1. Does your child have any chronic illness or medical condition we should know about? **YES or NO.** If yes, what? \_\_\_\_\_
2. Has your child ever wheezed with colds? Or has asthma? **YES or NO**
3. Has your child been diagnosed with Guillian-Barre Syndrome? **YES or NO**
4. Is your child allergic to eggs? **YES or NO**
5. Has your child ever had a reaction from the flu vaccine? **YES or NO**
6. Has your child received the seasonal nasal spray or vaccine last year? **YES or NO.** 2 doses? \_\_\_\_\_
7. Has your child had a fever or been sick in the last day? **YES or NO**

I give permission for my child to receive seasonal flu vaccine this year.  
**YES NO**

Please sign & date below:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Seasonal flu permissionslip2015/16