Flu Shot Record Form

Patient Information

Name: _____

Address: _____

City/Town: _____ State: _____ Zip: _____

Telephone: _____ _____
Home Cell or Work

Student Information

Student ID #: _____ Class of: _____

Flu Shot Information

Date Administered: _____/_____/_____

Manufacturer of Flu Shot Solution: _____

Expiration Date of Flu Shot Solution: _____Lot #: _____

HealthCare Provider Name:_____Phone Number:_____

Facility/Clinic Address:_____

City:_____ State:_____ Zip:_____

HealthCare Provider Signature:_____ Date:_____/_____/_____