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: ___/___/____

Updated 11/13 OR