DREXEL UNIVERSITY
College of
Nursing and
Health Professions

Seasonal Influenza Form

Name: ______________________ Date: ______________________

University ID: ______________________

Program: ☐ HSAD ☐ Co-op ☐ CAT ☐ MSN: NP ☐ NS/ISPP ☐ PA ☐ MSN: Advanced Role
(please check one) ☐ ACE ☐ DNP ☐ COFT ☐ NUAN ☐ PTRS ☐ DPT ☐ Other

Seasonal Influenza

Date Received: ______________________

Signature: ______________________

Health Care Provider Information

Name: ______________________

Address: *Street:* ______________________ City: ______________________ *State:* ____

Phone Number: ______________________