



## Seasonal Influenza Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

University ID: \_\_\_\_\_

### Vaccine Information

Date: Received: \_\_\_\_\_

Lot number: \_\_\_\_\_

Manufacturer: \_\_\_\_\_

### Health Care Provider Information

Name: \_\_\_\_\_

Address \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Phone number: \_\_\_\_\_

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