University of Pittsburgh Johnstown

Nursing Division

**Influenza Vaccine Documentation**

**Student Information**

(ALL FIELDS MUST BE COMPLETED)

STUDENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_

(LAST) (FIRST) (MI)

STUDENT ID#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STUDENT PITT EMAIL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

STUDENT CELL PHONE #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE COMPLETED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Health Care Provider to Complete**

INFLUENZA VACCINE DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_LOT #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(MONTH/DAY/YEAR)

FACILITY WHERE VACCINE WAS ADMINISTERED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEALTH CARE PROVIDER SIGNATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(A DOCUMENTATION OF VACCINE FORM FROM A HEALTH CARE PROVIDER OR SETTING CAN BE UPLOADED WITH THIS FORM IN LIEU OF A SIGNATURE.)

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**THIS COMPLETED FORM MUST BE UPLOADED TO EXXAT BY**

**OCTOBER 1ST.**

**YOU WILL NOT BE PERMITTED TO ATTEND ANY CLINICAL ROTATION WITHOUT A**

**FLU VACCINATION.**