NORTHWEST
MISSISSIPPI COMMUNITY COLLEGE

FLU VACCINE DOCUMENTATION

DATE OF VACCINATION: _____

NAME OF PERSON RECEIVING VACCINE: _____

NAME OF FLU VACCINE: _____

EXPIRATION DATE: _____

LOT NUMBER OF VACCINE: _____

SITE OF INJECTION: _____

SIGNATURE OF PERSON GIVING VACCINE: _____

PLACE HEALTH CARE PROVIDER/ HEALTH CARE FACILITY STAMP BELOW:
IF STAMPS ARE NOT AVAILABLE, HEALTH CARE PROVIDER, PLEASE PRINT NAME, ADDRESS, AND PROVIDE SIGNATURE:

Name: _____

Address: _____

Phone Number: _____

Signature: _____