

How do you do healthy?

Flu Shot Verification Form

This form verifies that the individual below received a flu vaccination from TotalWellness.

Participant Information:

.....
This section is to be completed by the participant.

First Name: _____

Last Name: _____

Event Location: _____

Participant Signature: _____

Date Signed: _____

Vaccination Information:

.....
This section is to be completed by the TotalWellness Nurse.

Event ID #: _____

Date Flu Vaccine Administered (mm/dd/yyyy): _____

Administering Nurse's Name: _____
(Print Full Name of Nurse)

Administering Nurse's Signature: _____
(Nurse Signature)

Vaccine Lot #: _____

Vaccine Manufacturer: _____

Vaccine Expiration Date: _____