



## Flu Shot Verification Form

Name of Employee: \_\_\_\_\_

DOB: \_\_\_\_\_

District: \_\_\_\_\_

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

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

### **Vaccination Information: (To be completed by provider)**

Date Flu Vaccine Administered: \_\_\_\_\_

Administering Person's Name: \_\_\_\_\_

Vaccine Lot #: \_\_\_\_\_