



COLUMBIA UNIVERSITY
MEDICAL CENTER

Student Health Service

INFLUENZA VACCINE OUTSIDE DOCUMENTATION FORM

Participation in the influenza vaccination program is required for all clinical students at Columbia University Medical Center. The following individual has received the influenza vaccine:

Patient's Name: _____ UNI _____

Date of Birth: ____/____/____

Date of Administration: ____/____/____

Flu Vaccine: Lot# _____ Expiration Date: _____

Administered by:

RN/HCP/Pharmacist Signature: _____

Print Name & Title: _____

License #: _____

Office Address: _____
(Stamp) _____

Telephone #: _____

Vaccination documentation on an office letterhead/prescription is also accepted; it must contain all the information noted above.