Washtenaw Community College | HEALTH SCIENCES NURSING

Questions? Email:
nursingprogramdocs@wccnet.edu

VERIFICATION OF SEASONAL FLU SHOT ADMINISTRATION

TO BE FILLED OUT BY THE STUDENT:

First Name:	Last Name:

TO BE FILLED OUT BY THE HEALTHCARE PROVIDER:

Date Administered:	Flu Vaccine Lot #:	Expiration Date:
Site of Injection: ☐ Left Deltoid ☐ Right Deltoid	Route: ☐ IM ☐ Other: _____	
Provider Signature/ Date:		

Upload Verification of Seasonal Flu Vaccine to your Student Tracker