

## Annual Influenza Immunization Form

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

Employee Title: \_\_\_\_\_

**\*\*\*Area Below to be Completed by Administering Practitioner\*\*\***

### Influenza Vaccine

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

Administration Site:     Left Deltoid     Left Deltoid

Manufacturer & Lot & Expiration Date:

\_\_\_\_\_

Administering Practitioner

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

Title: \_\_\_\_\_