



**Flu Shot Verification Form**

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

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

District/College: \_\_\_\_\_

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

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

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

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

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

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