INDIAN HILLS COMMUNITY COLLEGE
Life. Changing.

Health Sciences Influenza Form

TO BE COMPLETED BY THE STUDENT: **Birthdate** (mm/dd/yy) _ _ /_ _ /_ _

Last Name_____ **First Name**_____ **Middle**_____

Address_____**City**_____**State**_____**Zip**_____

How do you rate your general health? _____ **Do you have any physical or emotional limitations that might hinder your ability to perform the duties and responsibilities of the program you have selected?** _____**Yes** _____**No** **If yes, please explain**_____

_____

_____ _____ _____

Student Signature **Date** **Health Science Program**

Influenza Vaccine (October through March)

Name of the Facility you received this Vaccine:

_____

Street Address of Facility you received this Vaccine:

City:_____ **State:**_____ **Zip code:**_____

Date Influenza Vaccine was given: _____

Brand Name of Vaccine (examples: Flublok, Fluzone):

Manufacture Name of above listed brand name:

Lot Number of Vaccine: _____**Exp. Date of Vaccine:** _____

Injection site: Left Deltoid _____ **Right Deltoid:** _____

Specify if other site: _____

Printed name of Individual Administering vaccine:

_____

Signature & Date of Individual Administering vaccine:

_____

Falsification of medical records will result in disciplinary action which may include dismissal from the Program.