



**PROOF OF FLU**  
**2023 - 2024 SEASONAL FLU VACCINE INFORMATION**  
*Due September 22*

**NURSING STUDENT INFORMATION**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_

KSU ID# 000 \_\_\_\_\_

**NURSING STUDENT'S SIGNATURE**

**DATE SIGNED**

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\_\_\_\_\_

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*\*This section to be completed by Administering Professional\**

FACILITY NAME:

ADDRESS/STAMP:

DATE OF ADMINISTRATION:

DELTOID OF ADMINISTRATION:

VACCINE MANUFACTURER & EXPIRATION DATE:

**ADMINISTERING PROFESSIONAL'S INFORMATION**

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_

**ADMINISTERING PROFESSIONAL'S SIGNATURE**

**TITLE**

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