



The Barbara H. Hagan School of Nursing & Health Sciences

FLU VACCINE FORM

PLEASE PRINT

Student Name

Molloy ID Number

E-Mail Address

Phone Number

Course & Section

Entire form must be completed

Manufacturer or Company Name of Vaccine

Lot Number of the Vaccine

Expiration Date

Dose Administered

Date Administered

Placement

Right Deltoid

Left Deltoid

Name of Provider

License Number

Stamp

Address of Provider

DUE OCTOBER 1st