INFLUENZA VACCINATION REPORT

Date this form completed _____

School Name

_____

Name of Person completing form _____

Phone _____ Fax _____

Please list all students caring for patients at The Valley Hospital during this Influenza season and complete all information as accurately as possible. Return form to Ann Ennis (AEnnis@valleyhealth.com). Interoffice mail it to her: Nursing Professional Development, LL Hospital. Thank you.

Student/Instructor Names	Did you receive an influenza vaccination this season?	If yes, did you receive the vaccine at The Valley Hospital?	If not, where did you receive the vaccine? (Give Location)	Do you have a medical contraindication to the vaccine?	Were you offered the vaccine and declined?

Student/Instructor Names	Did you receive an influenza vaccination this season?	If yes, did you receive the vaccine at The Valley Hospital?	If not, where did you receive the vaccine? (Give Location)	Do you have a medical contraindication to the vaccine?	Were you offered the vaccine and declined?