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SCHOOL OF NURSING
UNIVERSITY OF MICHIGAN

VERIFICATION OF SEASONAL FLU SHOT ADMINISTRATION 2019-2020 Academic Year

TO BE FILLED OUT BY THE STUDENT

First Name		Last Name
Uniqname	UM ID	Phone Number

TO BE FILLED OUT BY THE HEALTHCARE PROVIDER

SEASONAL FLU SHOT ADMINISTRATION			
Date Administered	Flu Vaccine Lot#		
Healthcare Provider's Name and Title (Please Print)			
Signature			
Healthcare Center/Facility			
Address	City	State	Zip
Phone	Email Address		