



## VERIFICATION OF SEASONAL FLU SHOT ADMINISTRATION 2021-2022 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	