PLATT COLLEGE

Standardized Immunization Form: Flu Only

Patient Section

Last Name:		**First Name:**		**Middle Initial:**	
DOB:		**Street Address:**			
Last 4 SS#:		**City:**			
Phone:		**State:**			
Email:		**ZIP Code:**			

Below Section: MUST BE COMPLETED BY YOUR HEALTHCARE PROVIDER

Printed Name of Healthcare Provider:	
Title:	
Address Line 1:	
Address Line 2:	
City:	
State:	
ZIP Code:	
Phone:	
Fax:	
Email Contact:	

Authorized Signature of Healthcare Provider: _____

Date: _____

PLATT COLLEGE

Name: _____ **Date of Birth:** _____
(Last, First, Middle Initial) (mm/dd/yyyy)

Influenza Vaccine – One (1) dose annually each fall			
Influenza Vaccine		Date	Documentation
	Flu Vaccine	_____/_____/_____	Must Provide Documentation
	Flu Vaccine	_____/_____/_____	Must Provide Documentation
	Flu Vaccine	_____/_____/_____	Must Provide Documentation
	Flu Vaccine	_____/_____/_____	Must Provide Documentation