Annual Influenza Vaccine
Department of Nursing

Instructions: Student must complete section A or B.

Name (Please Print)_____Student I.D.#_____
Last Name First Name

A. INFLUENZA VACCINE

Injection Date: _____ Due by January 1st of each year (date subject to change).

HEALTH CARE PROVIDER INFORMATION

Practitioner's Signature:_____ Print Name:_____ Date:_____

Licensed as: Physician _____ ARNP _____Physician Assistant _____ RN _____ OTHER_____

License Number: _____ State Licensed: _____

B. DECLINE INFLUENZA VACCINE

☐ DECLINE TO RECEIVE VACCINATION _____ _____
Student's Signature Date

I understand that if I do not receive the influenza vaccination due to any reason, I will be required to wear a mask at all times during the flu season while in patient care areas. A patient care area is any place that patients are being cared for such as nursing units/departments, imaging areas, procedural areas, etc.