

SOUTHERN ILLINOIS UNIVERSITY  
**EDWARDSVILLE**  
SCHOOL OF NURSING

**Influenza Vaccination Form**

Student Name \_\_\_\_\_

SIUE ID # \_\_\_\_\_

Date of vaccination \_\_\_\_\_

Provider Signature/Credentials \_\_\_\_\_

-----

If influenza vaccine not given, state reason:

\_\_\_\_\_

\_\_\_\_\_

Provider Signature/Credentials \_\_\_\_\_

***Directions for Students: Take form to person/unit administering vaccine. Have it completed and return to program secretary. Deadline is end of Fall semester.***