AFFILIATED PHYSICIANS
A Leader in Corporate Healthcare Solutions

Vaccination Receipt Form

Date: ___/___/2019

Please complete the following information:

Company Name: Abbott

Location Name: _____

Name: _____

Signature: _____

----VACCINE ADMINISTRATION INFORMATION – CLINICIAN USE ONLY----

Injection Site (IM delivery): [ ] R Deltoid 0.5 mL [ ] L Deltoid 0.5 mL

MFR: _____ **Brand:** _____

Lot Number: _____ **Exp. Date:** _____**/2020**

RN Name: _____

RN: Please sign below indicating that you administered a flu shot to the above named patient.

RN Signature: _____ **Date:** _____

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