# INFLUENZA VACCINE OUTSIDE DOCUMENTATION FORM

Please select a campus:

- Columbia Univ. Irving
- Lawrence
- Lower Manhattan
- Westchester
- Weill Cornell

The above individual has received the influenza vaccine:

**Date of Administration:** _____/____/____

**Specific Vaccine Formulation:**
Vaccine Brand Name (e.g. Afluria, Fluarix, etc; will not accept generic name such as trivalent, quadrivalent, flu shot): ______________________ & One dose administered.

**Administering Licensed Healthcare Provider’s Name:** ________________________________
**Title:** ________________________________
**Signature:** ________________________________
**Telephone #:** (____) __________________

For questions regarding influenza or the vaccine please email us at fluquestions@nyp.org

Vaccination documentation on an office letterhead/prescription is also accepted; it must contain all the information noted above.

Please email your documentation form/letter to: whs-datamanagement@nyp.org

AC (REV. 1/4/18)