INFLUENZA VACCINE OUTSIDE DOCUMENTATION FORM

Please select a campus:

☐ Weill Cornell  ☐ Columbia Univ Irving  ☐ Lower Manhattan  ☐ Westchester  ☐ Lawrence

The above individual has received the influenza vaccine:

Date of Administration: _____/_____/____

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

Administering Licensed Healthcare Provider’s Information

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