The UNIVERSITY of VERMONT
COLLEGE OF NURSING & HEALTH SCIENCES

Name _____
Student ID # _____
Date of Birth _____
Program/Graduation Year _____
Phone# _____
Email _____
Date _____

INFLUENZA VACCINE PRE-CLINICAL REQUIREMENT

COPIES OF MEDICAL RECORDS/LABS WILL NOT BE ACCEPTED.

Influenza Vaccination

Date Administered _____ Manufacturer _____

Lot Number _____ Expiration Date _____

If given at a separate time, please provide documentation of influenza vaccination

Licensed Heath Care Provider Attestation

By signing below, I affirm that I am a licensed health care provider. I am aware that leaving any required fields blank will result in the student being **unable to progress in his/her major** at the University of Vermont.

Signature of **Licensed Health Care Provider** **Credentials** Date

Clinic Stamp or Printed Name of Provider Provider Telephone Number

It is MANDATORY that you scan and upload this form to CastleBranch

Please note, UVM Student Health will not submit your paperwork for you. You will need to pick up your documents and submit them to CastleBranch.

The information included on this form maybe released to the infection control officer and clinical education coordinators at sites where you perform your clinical education experience.