McLaren HEALTH CARE

DOCUMENTATION OF INFLUENZA VACCINATION

Please complete this form if you received your influenza vaccination at a facility other than McLaren Employee Health. Date administered and LOT number are required fields.
Print legibly please. Difficult to read documents will not be entered.
Thank you.

Name (printed): _____ DOB: _____

EEID #: _____ Social Security Number: **xxx-xx-** _____

McLaren Facility Location: _____ Department: _____

Please Check One:

☐ Employee ☐ Non-Employed Provider
☐ **Contractor** ☐ **Volunteer/Student**

THIS SECTION MUST BE COMPLETED BY THE HEALTHCARE PROVIDER ADMINISTERING THE VACCINE

0.5 mL in _____R _____L Deltoid

_____ Manufacturer

_____ Lot Number

__/__/__ Expiration Date

_____ Healthcare Provider printed name

_____ Healthcare Provider signature

__/__/__ Date Received

_____ Address, City, State, Zip

Office Stamp

PLEASE RETURN THIS FORM TO YOUR LOCAL EMPLOYEE HEALTH DEPARTMENT OR SCAN AND EMAIL TO employee.health@McLaren.org