KENNESAW STATE UNIVERSITY
WELLSTAR COLLEGE OF HEALTH AND HUMAN SERVICES
School of Nursing

PROOF OF FLU
2024 - 2025 SEASONAL FLU VACCINE INFORMATION

NURSING STUDENT INFORMATION

LAST NAME _____ FIRST NAME _____

KSU ID# _____

NURSING STUDENT'S SIGNATURE **DATE SIGNED**

_____ _____

This section to be completed by Administering Professional

FACILITY NAME:

ADDRESS/STAMP:

DATE OF ADMINISTRATION:
DELTOID OF ADMINISTRATION:

VACCINE MANUFACTURER & EXPIRATION DATE:

ADMINISTERING PROFESSIONAL'S INFORMATION

LAST NAME _____ FIRST NAME _____

ADMINISTERING PROFESSIONAL'S SIGNATURE **TITLE**

_____ _____