



GEORGIA HIGHLANDS COLLEGE

PROOF OF FLU
NURSING STUDENT INFORMATION
2024-2025 SEASONAL

FIRST NAME: _____ LAST NAME: _____

GHC ID#: _____ CURRENT CLASS: _____

ADMINISTRATING FACILITY: _____

ADDRESS/STAMP:

DATE OF ADMINISTRATION: _____

SITE LOCATION: () R deltoid () L deltoid

VACCINE: _____

VACCINE MANUFACTURER: () SANOFI-PASTEUR () GLAXOSMITHKLINE () SEQIRUS

() OTHER: _____

VACCINE LOT#: _____ NDC#: _____

VACCINE EXPIRATION DATE: _____

ADMINISTERING IMMUNIZER SIGNATURE: _____

NURSING STUDENT'S SIGNATURE

DATE