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**Employee Health**

**OFF-SITE INFLUENZA VACCINATION FORM**

**FOR Volunteers, Contract Staff, Licensed Independent Practitioners and Students**

**Off-site meaning: received vaccine outside of Employee Health**

Name \_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

(Please print)

Personal Phone No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check one:

Volunteer

Student (School Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Non-Carilion Provider (Job \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Contract (Department \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I had my influenza vaccine at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on the date of \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_.

**Proof of vaccination is required and must be attached to this form.** The following are acceptable forms of proof:

□ My Chart documentation □ Retail pharmacy documentation

□ Note from medical provider with your name, date vaccine received, type of influenza vaccine

**Please check every Carilion facility/location you will be during your student assignment:**

□ Carilion Roanoke Memorial Hospital □ Carilion New River Valley Hospital

□ Carilion Giles Community Hospital □ Carilion Franklin Memorial Hospital

□ Carilion Stonewall Jackson Hospital □ Carilion Roanoke Community Hospital

□ Carilion Tazewell Community Hospital □ St. Albans – NRV

□ Psychiatry Rehab □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please submit this form and proof of vaccination to Carilion’s Visiting Student Affairs**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Signature

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