**** Employee Health**

**OFF-SITE INFLUENZA VACCINATION FORM**

**For Students**

**“Off-site” meaning received vaccine outside of Carilion Employee Health**

**Name \_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_** (Please print) **Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Personal Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Please choose ONE option below and fill in accordingly:**

**Option 1:** I had my influenza vaccine **OUTSIDE OF CARILION** at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ on this date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_.

**Option 2: For Carilion employees who are students only.** I received my influenza vaccine **AT CARILION EMPLOYEE HEALTH (EH)**. Please indicate which EH site below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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 (VSA).**

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