Influenza Vaccine Doses Administered Worksheet

Report Period

Page _____ of _____

_____ _____ _____
week month year

Contact Person _____
Contact Phone (_____) _____-_____

Provider Name_____
Street Address_____ City_____ County_____

Patient Name Last, First, MI	**Birth Date** MM/DD/YR	**Eligibility/ Insurance** Non-Medicaid Part B	Private Self Pay	**Service Date** MM/DD/YR	**Dose 1**	**Dose 2**	**Priority Group or High Risk? (specify)**
Column Totals:							