Seattle Visiting Nurse Association

VERIFICATION OF 2023 INFLUENZA AND/OR MODERNA COVID VACCINATION

Patient Name: _____

Date of Birth: _____/_____/_____

Date of Vaccination(s): _____/_____/_____

Clinic Location: _____

TYPE(S) OF VACCINES ADMINISTERED

☐ Flucelvax Quadrivalent (Preservative-Free) Lot#: _____ Exp. Date: _____/_____/_____

Manufacturer: Seqirus

☐ Covid-19 Spikevax Lot#: _____ Exp. Date: _____/_____/_____

Manufacturer: Moderna

Authorized By: _____ Print Name: _____

(signature)

Seattle Visiting Nurse Association
170 W Dayton St
Suite 103A
Edmonds, WA 98020
(425) 967-3080
info@seattlevna.com