Upload this form to your CastleBranch folder.
Please keep the original documents.

NEW YORK INSTITUTE OF TECHNOLOGY
School of Health Professions

PA STUDIES
INFLUENZA VACCINATION FORM

To be completed by student:

Last Name, First Name:_____Date of Birth:_____

New York State requires that all healthcare personnel who have the potential to have any patient contact whatsoever, including students, to receive an annual seasonal influenza vaccination. Students may not participate in any clinical or patient contact if they have not been vaccinated against seasonal influenza, unless they have a specific contraindication to the influenza vaccine as documented by a physician, PA or nurse practitioner.

When to get vaccinated: https://www.cdc.gov/flu/about/season/index.html

To be completed by healthcare professional – Seasonal Influenza Vaccination:

☐ **A Seasonal Influenza Vaccine has been administered that is approved for the current flu season**

Approved for Flu Season (years): 202____ to 202____

Date Administered:_____ Lot Number:_____

☐ **The above student has a contraindication to receiving the seasonal influenza vaccination. (Please enclose medical documentation supporting this exemption)**

_____
Healthcare provider signature

Date: _____

(X)00002102019SR

(REQUIRED)
Stamp of provider and/or health care facility*

*Vaccine label can also be included as proof