Meningitis Immunization Verification Form

I certify that

Patient’s Last Name

Patient’s First Name

Patient’s Date of Birth

Patient’s UConn ID #

Received:  {check one please}  □ Menactra (USA)
           □ Menveo (USA)
           □ Mencevax (outside of USA)
           □ Nimenrix (outside of USA)

Vaccination date: ____________________________

Provider Signature_________________________ Date ____________________

Provider Name and Practice Address (printed) _______________________________________

_______________________________________

_______________________________________

Please mail this form to:  University of Connecticut
                          Student Health Services
                          234 Glenbrook Rd, Unit 4011
                          Storrs, CT 06269-4011

Or fax to:  860-486-5300