UCONN
UNIVERSITY OF CONNECTICUT

Division of Student Affairs
Student Health Services
Counseling and Mental Health Services

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