

## Meningitis Vaccine Record

Name \_\_\_\_\_ ID# \_\_\_\_\_

Received:     a) Menomune  
                  or  
                  b) Menactra vaccine on \_\_\_\_\_

Lot # \_\_\_\_\_ Expiration Date <sup>date</sup> \_\_\_\_\_

\_\_\_\_\_  
Health Care Representative

\_\_\_\_\_  
Address

Return to the Engle Center by June 15th.

For your convenience our fax: 717- 796- 5372