McMurry University

Bacterial Meningitis Immunization Notification Form

To be completed by the immunization provider or pharmacy

Please complete all applicable fields. This form documents a bacterial meningitis vaccination administered to the student named below.

Provider and Student Information

Pharmacy name

Student name

Patient name

Date of birth

Immunization Information

Vaccine administered	Dose	Route
Meningitis Vaccination	0.5 mL	IM

Injection site

Date administered

Product name

NDC

Lot number

Expiration date

Manufacturer

Pharmacy Information

Store number

Pharmacy phone

Pharmacy address - line 1

Pharmacy address - line 2

Certification

I certify that the immunization information provided on this form is accurate to the best of my knowledge.

Immunization certified pharmacist signature