Evidence of Vaccination Against Bacterial Meningitis

This form may be used by any new or returning student to Texas A&M University in order to satisfy the requirement to submit evidence of a bacterial meningitis vaccination, in compliance with Texas Education Code 51.9191/51.9192 *et seq.* and THECB Rule 21.610 *et seq.*
The preferred method is to upload the form via the Application Information System (AIS) or the form can be delivered to the Office of Admissions: General Services Complex Suite 1601, P.O. Box 30014 College Station, TX 77842-3014,

SECTION A. This section should be completed by the student

Student Last Name: _____ Student First Name: _____

UIN: _____ Date of Birth: _____ / _____ / _____
Month Day Year

Telephone Number: _____ Preferred Email Address: _____

Intended semester of enrollment at Texas A&M University (Select one and indicate the appropriate year):

□ Spring, Year: _____ □ Summer, Year: _____ □ Fall, Year: _____

Level of study:
□ Undergraduate □ Graduate

Please initial the appropriate statement:

_____ My health practitioner has completed and signed Section B of this form as required.

_____ I have attached to this form a true and complete copy of an official immunization record evidencing I have received a bacterial meningitis vaccination dose or booster during the five (5) year period prior to the start of the semester for which I have applied. Section B below is *not* completed.

_____ I have attached an affidavit or certificate signed by a physician who is duly registered and licensed to practice medicine that states the vaccination would be injurious to my health and well-being. Section B below is *not* completed.

_____I have attached a conscientious exemption form from the Texas Department of State Health Services. Section B below is *not* completed.

By signing this form, I certify that the information provided is true and accurate. I acknowledge receiving information from the university about the bacterial meningitis vaccination requirement.

Student Signature: _____ Date _____ / _____ / _____
Month Day Year

SECTION B. This section should be completed by a licensed Health Practitioner or Designee.

Last/Family Name of the Health Practitioner who administered the vaccination: _____

First/Given Name of the Health Practitioner who administered the vaccination: _____

Date of the administration of the bacterial meningitis vaccination: _____ / _____ / _____
Month Day Year

Last/Family Name of the vaccination recipient (i.e. the student): _____

First/Given Name of the vaccination recipient (i.e. the student): _____

Date of birth of the vaccination recipient (i.e. the student): _____ / _____ / _____
Month Day Year

By signing this form, I certify that the information provided is true and accurate. Specifically, I certify the following:

- I am a Health Practitioner authorized by law to administer an immunization or I have legal designation to complete and sign this form on behalf of a Health Practitioner authorized by law to administer an immunization.
- The individual who administered the bacterial meningitis vaccination to the student named above is or was a Health Practitioner authorized by law to administer an immunization.
- The bacterial meningitis vaccination was administered to the student named above by the Health Practitioner named above and on the date provided above.

Health Practitioner or Designee Signature: _____ Date _____ / _____ / _____
Month Day Year

License Number: _____Organization/Facility: _____Phone: _____