

Evidence of Bacterial Meningitis Vaccination

Instructions: This form may be completed by participants at the Texas A&M Engineering Extension Service (TEEX) in order to satisfy the requirement of submitting evidence of a bacterial meningitis vaccination in compliance with Texas Education Code 51.9191/51.9192 *et. seq.* and Texas Higher Education Coordinating Board (THECB) Rule 21.610 *et. seq.*

Section A (Participant)

Participant First Name:

Participant Last Name:

Telephone Number:

Preferred Email Address:

Please initial the statement that is applicable to you:

- _____ 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 proof of immunization or an official record evidencing I have received a bacterial meningitis vaccination dose or booster during the five (5) year period prior to the start of the course or program 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 agency about the bacterial meningitis vaccination requirement.

Participant Signature

Date

Section B (Licensed Health Practitioner or Designee)

Health Practitioner Administering Vaccine

First/Given Name:

Last/Family Name:

License Number:

Telephone Number:

Vaccination Recipient

First/Given Name:

Last/Family Name:

Date of Birth:

Date of bacterial meningitis vaccination administration:

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 Participant named above is or was a Health Practitioner authorized by law to administer an immunization.
- ☐ The bacterial meningitis vaccination was administered to the individual named above by the Health Practitioner named above and on the date provided above.

Health Practitioner or Designee Signature

Date