

Evidence of Vaccination against Bacterial Meningitis

Purpose of Form: This form may be used by any participant at The Texas A&M Engineering Extension Service 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.*

SECTION A. This section should be completed by the Participant

Participant Last Name: _____ Participant First Name: _____

Telephone Number: _____ Preferred Email Address: _____

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 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. This section must 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: _____

Last/Family Name of the vaccination recipient:

First/Given Name of the vaccination recipient:

Date of birth of the vaccination recipient: _____

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 _____

License Number: _____ Phone: _____