

## Bacterial Meningitis Immunization Record

**Notice: THIS FORM IS DUE TEN (10) DAYS PRIOR TO THE FIRST DAY OF CLASS**

Purpose of this form: This form may be used by any student under the age of **22** entering the UNT Health Science Center in order to satisfy the requirement to submit evidence of a bacterial meningitis vaccination, in compliance with Texas Senate Bill 1107.

STUDENT INFORMATION			
UNTHSC Student ID #  _____	Enrollment Term (Check One) <input type="checkbox"/> Fall <input type="checkbox"/> Summer: 3 Week/5 Week 1/10 Week <input type="checkbox"/> Spring <input type="checkbox"/> Summer: 5 Week 2	Year  _____	
Last Name  _____	First Name  _____	Middle Initial  _____	
Mailing Address  _____		Apartment #  _____	Daytime Phone #  _____
City  _____		State  _____	Zip Code  _____
Date of Birth  ____/____/____ <small>Month    Day    Year</small>	Age  _____	Email Address  _____	

### SELECT OPTION 1 OR 2

<input type="checkbox"/> <b>Option 1: Select type of attachment (Documentation must be in English or accompanied by a notarized translation)</b>
<input type="checkbox"/> Official copy of immunization record stating the type of vaccine administered and signed by a Health Care Provider <input type="checkbox"/> Medical Exemption affidavit or certificate <input type="checkbox"/> <a href="#">Texas Department of State Health Service Exemption for Reasons of Conscience form</a> <input type="checkbox"/> Official immunization records generated by a state or local health authority <input type="checkbox"/> Official immunization record received from school official, including a record from another state
<input type="checkbox"/> <b>Option 2: To be completed by a Health Care Provider - USE BLACK INK</b>

Date of Immunization  ____/____/____ <small>Month    Day    Year</small>	Official Stamp: Health Care Provider's Name, Address, and Phone Number  _____
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Signature and Title of Health Care Provider  _____	Date  ____/____/____ <small>Month    Day    Year</small>
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**I have read and understand the Bacterial Meningitis immunization requirements. I certify that, to the best of my knowledge, the above information (including attached copies) is true and correct.**

Student's Signature - <b>USE BLACK INK ONLY</b>  _____	Date  ____/____/____ <small>Month    Day    Year</small>
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Office Use Only	
Date Received  ____/____/____	<input type="checkbox"/> Accepted <input type="checkbox"/> Denied <input type="checkbox"/> Incomplete
Date Completed  ____/____/____	Completed By _____