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,

<table>
<thead>
<tr>
<th>SECTION A. This section should be completed by the student</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Last Name: ___________________________</td>
</tr>
<tr>
<td>UIN: ___________________________</td>
</tr>
<tr>
<td>Telephone Number: ___________________________</td>
</tr>
</tbody>
</table>

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 ____________ / ____________ / ____________ |

<table>
<thead>
<tr>
<th>SECTION B. This section should be completed by a licensed Health Practitioner or Designee.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last/Family Name of the Health Practitioner who administered the vaccination: ___________________________</td>
</tr>
<tr>
<td>First/Given Name of the Health Practitioner who administered the vaccination: ___________________________</td>
</tr>
<tr>
<td>Date of the administration of the bacterial meningitis vaccination: ____________ / ____________ / ____________</td>
</tr>
</tbody>
</table>

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): ____________ / ____________ / ____________

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 ____________ / ____________ / ____________ |

License Number: ___________________________ | Organization/Facility: ___________________________ | Phone: ___________________________ |