LAMAR UNIVERSITY

Bacterial Meningitis Evidence of Vaccination or Medical Exemption

Purpose of Form: This form may be used by any incoming student to Lamar University in order to satisfy the requirement to submit evidence of a bacterial meningitis vaccination, in compliance with Texas Senate Bill 1107 (MCV4, A, C, W, Y). The complete form can be hand-delivered, mailed, faxed, or emailed to the Records Office, Wimberly 102; Records Office, P.O. Box 10010, Beaumont, TX 77710; Fax: (409) 880-7769, Email: immunize@lamar.edu or immunization@lamar.edu

This section should be completed by the student

Student Last Name: _____ Student First Name: _____

Student ID Number: _____ Date of Birth: _____/_____/_____
Month Day Year

Telephone Number: _____ Preferred Email Address: _____

First Semester at Lamar University (Select one and indicate the appropriate year):

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

By signing this form, I certify that the information provided is true and accurate and I understand the rules and regulations concerning the bacterial meningitis vaccination requirement.

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

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.

OR: The student has not been immunized against Bacterial Meningitis based on the conclusion at this time that it would be injurious to the student's health.

Comments _____

_____

_____

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

License Number: _____ Phone: _____

Address of Medical Facility: _____