**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:** _________/_______/_______
- **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:** _________/_______/_______

**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:** _________/_______/_______
- **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 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:** _________/_______/_______
- **License Number:** __________
- **Phone:** __________
- **Address of Medical Facility:** __________