**Return this completed form to:** UNT Health Science Center Office of the Registrar, SSC 244



3500 Camp Bowie Blvd. Fort Worth, TX 76107-2644

FAX: (817) 735-0448 OR Email: [Health@unthsc.edu](mailto:Health@unthsc.edu)

**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) Year  Fall Summer: 3 Week/5 Week 1/10 Week  Spring Summer: 5 Week 2 | |
|  |  |  |  |
| Last Name |  | First Name | Middle Initial |
| Mailing Address |  | Apart | ment # Daytime Phone # |
| City |  | State | Zip Code |
| Date of Birth  Month Day Year |  | Age Email Addre | ss |

**SELECT OPTION 1 OR 2**

Option 1: Select type of attachment (Documentation must be in English or accompanied by a notarized translation)

Official copy of immunization record stating the type of vaccine administered and signed by a Health Care Provider Medical Exemption affidavit or certificate

[Texas Department of State Health Service Exemption for Reasons of Conscience form](http://webds.dshs.state.tx.us/immco/affidavit.shtm) Official immunization records generated by a state or local health authority

Official immunization record received from school official, including a record from another state

Option 2: To be completed by a Health Care Provider - **USE BLACK INK**

Date of Immunization

Month Day Year

Official Stamp: Health Care Provider's Name, Address, and Phone Number

Signature and Title of Health Care Provider

Date

Month Day Year

**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 - **USE BLACK INK ONLY**

Month Day Year

**Office Use Only**

Date Received Date Completed

Accepted Denied

Incomplete Completed By