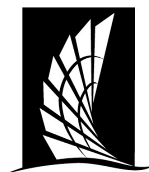

Texas A&M University-Corpus Christi
Office of Recruitment and Admissions

Evidence of Vaccination against Bacterial Meningitis

Purpose of Form: This form may be used by any new student to Texas A&M University-Corpus Christi 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 complete form can be hand-delivered, mailed, faxed or emailed to the Office of Recruitment and Admissions: 6300 Ocean Drive, Unit 5774, Corpus Christi, TX 78412-5774, Fax: 361.825.5887, Email: admiss@tamucc.edu

SECTION A. This section should be completed by the student

Student Last Name: ______________________________ Student First Name: ______________________________

UIN: ____ Date of Birth: ______________ / ______ / ________
Month Day Year

Telephone Number: __________________________ Preferred Email Address: __________________________

First Semester at Texas A&M University-Corpus Christi (Select one and indicate the appropriate year):

□ Spring, Year: ______________ □ Summer, Year: ______________ □ Fall, Year: ______________

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 ____________ / ______ / ________
Month Day Year

SECTION B. 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.

Health Practitioner or Designee Signature: _______________________________ Date _________ / ______ / ______
Month Day Year

License Number: _______________________________ Phone: ____