Evidence of Vaccination against Bacterial Meningitis

Purpose of Form: This form may be used by any incoming student to Howard College in order to satisfy the requirement to submit evidence of a bacterial meningitis vaccination, in compliance with Texas Senate Bill 1107. The complete form can be hand delivered, mailed, faxed or emailed to the appropriate Howard College/SWCID campus.

This section should be completed by the student

Student Last Name:______________________________Student First Name:________________________________

SS #:____Date of Birth:_____________________________________

Address:____

Telephone Number:__________________________ Preferred Email Address:______________________________

Please read and place an "x" next to the section that applies, sign, date and submit to your campus registrar

☐ I have received the Bacterial Meningitis Vaccine and attached an official vaccination record.

☐ My physician or health care professional has documented my meningococcal vaccine at the bottom of this form.

- **I understand that the vaccination must be administered 10 days prior to the start of classes.**
- **I understand that proof of the vaccination must include the physician or health care professional's signature, the date the vaccination was administered, the medical facility's stamp and seal, and contact information.**
- **I understand that I will not be allowed to register for courses at HC/SWCID without the Meningococcal Vaccine**.

Student Signature:____Date:___________________________

(Parent/Guardian if student is under 18 years of age)

This section should be completed by a licensed Health Practitioner or Designee.

Name of Administering Medical Facility:____

Address:____Phone #:___________________________

Name of Administering/Verifying physician or health professional:_______________________________________

Type of vaccination: ☐ MCV4 ☐ MPSV4

Date meningitis vaccination was administered:____

I hereby verify/confirm that the above named student received the mandated Bacterial Meningitis vaccine as required, and the information provided on this form is true and accurate.

Signature of physician/health care provider:___________________________________Date:____________________

Place Official Stamp Here	Place Official Seal Here