



Bacterial Meningitis Vaccination Verification Form

| | | | |
|---------------|--|----------------|--|
| Student Name: | | DCCCD ID: | |
| Address: | | Date of Birth: | |
| Telephone: | | Email Address: | |

Please read and place an "X" next to the section that applies, sign, date, and submit to your DCCCD Campus Registrar by mail, fax or in person.

- I am declaring a conscientious exemption, and am attaching the notarized Department of State Health Services affidavit form.
 - The link to the Conscientious Exemption form is <https://webds.dshs.state.tx.us/immco/affidavit.shtm>

- I have received the Bacterial Meningitis Vaccine within the last 5 years and am attaching an **official** vaccination record in English or serologic test of immunity.
 - The link to the DSHS immunization records is http://www.dshs.state.tx.us/immunize/immtrac/imm_providers.shtm

- 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 before I register for classes.
 - I understand that I must obtain the bacterial meningitis vaccination at least 10 days before the first day of class.
 - I understand that I will not be allowed to register for courses at DCCCD without the Meningococcal Vaccine
 - 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.

| | |
|--------------------|-------|
| Student Signature: | Date: |
|--------------------|-------|

Vaccine Verification and Medical Facility Information (Completed by Physician/Health Professional)

| | |
|---|----------|
| Name of Administering Medical Facility: | |
| Address: | Phone #: |
| Name of Administering/Verifying Physician or Healthcare Professional: | |
| Type of Vaccination: <input type="checkbox"/> MCV4 <input type="checkbox"/> MPSV4 <input type="checkbox"/> Other: | |
| Date meningitis vaccination was administered: | |

Note: Vaccine must be proven effective against Bacterial Meningitis and must be approved by Center for Disease Control (CDC). Please visit: www.cdc.gov/meningitis/vaccine-info.html

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

| | |
|---|-------|
| Signature of Physician/Healthcare Provider: | Date: |
|---|-------|

Place Official Stamp Here

Place Official Seal Here