Bacterial Meningitis Immunization Record

As a first-time, transferring, or returning student attending an institution of higher education, you must provide your school with evidence of vaccination against bacterial meningitis.

Student Last Name: ____________________  Student First Name: ____________________  Date of Birth: __/__/____

Vaccination Information

Please check the type of vaccine that was administered: __/__/____

- Meningococcal Conjugate Vaccine (MCV4)  Vaccine Administered Date: __/__/____
- Meningococcal Polysaccharide Vaccine (MPSV4)  Age of Student: __________

*Vaccine must be one of the two listed above, which have been approved by the CDC*

Physician/Health Practitioner - Print Name: ____________________

Physician/Health Practitioner - Signature: ____________________

Date Signed: __________

Practice/Hospital Name: ____________________

Physician or Health Practitioner / Practice Stamp: ____________________

Compliance Rules:
- Vaccine information must be in English
- An immunization record issued by a state or local health authority will be accepted
- The vaccine must be administered during the five-year period preceding, or at least 10 days prior to the first day of class

***Students*** This form must be submitted at least 10 days prior to the start of the semester in which you seek to enroll or you will not be allowed to register or attend classes.

Student ID #: ____________________  Discover the BUFF in You.