West Texas A&M UNIVERSITY

Evidence of Vaccination against Bacterial Meningitis

Purpose of Form: This form may be used by any incoming student planning to live on-campus at West Texas A&M University in order to satisfy their requirement to submit evidence of a bacterial meningitis vaccination, in compliance with Texas House Bill 4189. The complete form can be faxed, e-mailed, or hand-delivered to the office listed on this form.

This section should be completed by the student.

Last Name: ______ First Name: ______ ID: ______

Date of Birth: ______ Phone Number: ______ E-mail Address: ______

First Semester of On-Campus Residence at West Texas A&M University (Select one and indicate the appropriate year):

○ **Spring Year:** ______ ○ **Summer Year:** ______ ○ **Fall Year:** ______

By signing this form, I certify that the information provided is true and accurate; I understand the rules and regulations concerning the bacterial meningitis vaccination requirement for students living on-campus; and I agree to all conditions listed below.

- I will not receive a housing assignment until Student Medical Services (SMS) office and Residential Living have received evidence of my vaccination against bacterial meningitis or my affidavit declining vaccination. This form is one means that can be used to show proof of vaccination.
- I must obtain the bacterial meningitis vaccination at least 10 days before I may move in to my on-campus residence.
- If I obtain the bacterial meningitis vaccination less than 10 days prior to my scheduled move-in date, I will be responsible for securing temporary housing accommodations for myself until the 10 day required waiting period has been reached.

Student Signature: ______________________ **Date:** ____/____/____

This section should be completed by the licensed Health Practitioner or Designee who administered the vaccination.

Date of the administration of the bacterial meningitis vaccination: ______

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 below and on the date provided above.

Health Practitioner name (Print): ______________________

Health Practitioner or Designee Signature: ______________________ Date: ____/____/____

This section should be completed by the (SMS) Student Medical Services Department at West Texas A&M University.

Staff Member Name: ______ Date: ____/____/____

Staff Member Signature: ______________________

Student Medical Services

Address: *West Texas A&M University, Student Medical Services, WTAMU Box 61401*

Hand Delivery: *Virgil Henson Activities Center, Room 104*

Phone: *806-651-3287* ***E-mail:*** *lotoole@wtamu.edu* ***Website:*** *http://wtamu.edu/MedicalServices*