UNT®

UNIVERSITY OF NORTH TEXAS™

University of North Texas

Bacterial Meningitis Immunization Record

Please read the immunization requirements prior to completing this form. All applicable sections should be completed online prior to printing.

STUDENT INFORMATION

UNT Student ID #	Enrollment Term (Check One)	Year
	☐ Fall ☐ Summer: 3 Week/5 Week 1/10 Week ☐ Spring ☐ Summer: 5 Week 2	

Last Name	First Name	MI

Mailing Address	Apartment #	Daytime Phone #
		( ) -

City	State	Zip Code

Date of Birth	Age	Email Address
___/___/___		

SELECTION OPTION 1 OR 2

☐ **OPTION 1: Select type of attachment** (Documentation must be in English or accompanied by a notarized translation.)

- ☐ Official copy of immunization record stating the type of vaccine administered and signed by a Health Care Provider
- ☐ Medical Exemption affidavit or certificate
- ☐ Texas Department of State Health Services Conscientious Exemption form
- ☐ Official immunization records generated by a state or local health authority
- ☐ Official immunization record received from school officials, including a record from another state

☐ **OPTION 2: To be completed by a Health Care Provider - USE BLACK INK**

Date of Immunization	Official Stamp: Health Care Provider's Name, Address, Phone Number
___/___/___	

Signature and Title of Health Care Provider	Date
	___/___/___

I have read and understand the Bacterial Meningitis immunizations requirements. I certify that, to the best of my knowledge, the above information (including any attached copies) is true and correct.

Student's Signature (18 years of Age or Older) – USE BLACK INK ONLY	
	Date ___/___/___

MINORS: Students under 18 Years of Age

Signature of Parent or Guardian– USE BLACK INK ONLY	Date
	___/___/___

Full Name of Parent or Legal Guardian	Relationship to Student

Office Use Only

Date Received		
___/___/___	☐ Accepted ☐ Denied ☐ Incomplete	Date Completed ___/___/___ Completed By _____