

### Bacterial Meningitis Immunization Record Form

Please read the [Bacterial Meningitis immunization information](#) prior to completing this form.

ALL applicable sections should be completed ONLINE prior to printing.

STUDENT INFORMATION			
University of Houston-Victoria ID# (myUHV ID)		Date of Birth (MM/DD/YYYY)	
Enrollment Term (Semester and Year)			
Last Name	First Name	MI	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address		Apartment #	Phone Number:
City	State	Zip Code	Email Address

#### SELECT OPTION 1 OR 2

<input type="checkbox"/> <b>OPTION 1: Select type of attachment</b>	
<input type="checkbox"/> <b>A <u>COPY</u> of your official immunization record signed by a Health Care Provider</b> Documentation must be in English	Date of Immunization (MM/DD/YYYY)
<input type="checkbox"/> <b>Medical Exemption Letter or Certificate</b> Must be signed by a healthcare professional and specify timeframe of exemption	
<input type="checkbox"/> <b><a href="#">Texas Department of State Health Services Conscientious Exemption Form</a></b> (Submit <b>ORIGINAL</b> only, a copy will not be accepted)	
<input type="checkbox"/> <b>An official record received from school officials, including a record from another state</b>	

<input type="checkbox"/> <b>OPTION 2: To be completed by a Health Care Provider</b>	
Date of Immunization (MM/DD/YYYY)  <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px 0;"></div> Vaccine Administered: <input type="checkbox"/> MCV4 <input type="checkbox"/> MPSV4  <a href="#">Vaccine Information Statement</a>	Office 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. I also give my consent for the above immunization record to be entered into my electronic student record.	
Student's Signature - <b>REQUIRED</b>	Date
<b>MINORS: Student under 18 years of age</b>	
Signature of Parent or Legal Guardian – <b>REQUIRED</b> if student is under 18 years of age	Date
Printed Name of Parent or Legal Guardian	Relationship to Student

#### OFFICE USE ONLY

Document #	Date Received	<input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Incomplete	PS _____ By: _____
		By: _____ Emailed: _____	Log _____ By: _____

Return completed form and appropriate documentation to the Office of Admissions via fax: 361-580-5500 or email: [admissions@uhv.edu](mailto:admissions@uhv.edu)  
 Make a copy of your immunization documentation for your records. The university does not provide copies of immunization record submissions.