UNT DALLAS
UNIVERSITY OF NORTH TEXAS AT DALLAS

# 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 | | |
|---|---|---|
| **UNTD Student ID #** | **Enrollment Term (Check One)**<br>☐ Fall ☐ Summer: 3 Week/5 Week 1/10 Week<br>☐ Spring ☐ Summer: 5 Week 2 | **Year** |
| **Last Name** | **First Name** | **MI** |
| **Mailing Address** | **Apartment #** | **Daytime Phone #**<br>(  ) - |
| **City** | **State** | **Zip Code** |
| **Date of Birth**<br>__/__/__ | **Age** | **Email Address** |

## PLEASE COMPLETE ONE OF THE FOLLOWING TWO OPTIONS

☐ **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** (See paragraph 3 of page 1)<br>__/__/__<br>**Vaccine Administered**<br>☐ MCV4/Menactra ☐ MPSV4/Menomune | **Official Stamp: Health Care Provider's Name, Address, Phone Number** |
|---|---|
| **Signature and Title of Health Care Provider** | **Date**<br>__/__/__ |

**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. I authorize UNTD to communicate with me regarding my bacterial meningitis immunization requirements via electronic communication or by phone.**

| **Student's Signature (18 years of Age or Older) – USE BLACK INK ONLY** | |
|---|---|
| | **Date**<br>__/__/__ |
| **MINORS: Students under 18 Years of Age** | |
| **Signature of Parent or Guardian– USE BLACK INK ONLY** | **Date**<br>__/__/__ |
| **Full Name of Parent or Legal Guardian** | **Relationship to Student** |

| **Office Use Only** | | |
|---|---|---|
| **Date Received**<br>__/__/__ | ☐ Accepted ☐ Denied<br>☐ Incomplete | **Date Completed** __/__/__<br>**Completed By** _____ |