

University of Houston Clear Lake

PROOF OF BACTERIAL MENINGITIS IMMUNIZATION COMPLIANCE

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

STUDENT INFORMATION			
Student 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	
Student Status <input type="checkbox"/> New to UHCL <input type="checkbox"/> Returning-(Not enrolled for less than 1 year) <input type="checkbox"/> Readmit-(Not enrolled for more than 1 year)		Email Address	


SELECT OPTION 1 OR 2

OPTION 1: Select type of attachment
<input type="checkbox"/> A <u>COPY</u> of your official immunization record signed by a Health Care Provider Documentation must be in English or accompanied by a notarized translation
<input type="checkbox"/> Medical Exemption Affidavit or Certificate (<i>The law requires that you visit a doctor in the U.S. to be able to get an exemption for medical reasons.</i>)
<input type="checkbox"/> Texas Department of State Health Services Exemption Form (<i>Exemption for reasons of conscience including religious beliefs.</i>) Submit ORIGINAL only, a copy will not be accepted


OPTION 2: Physician or Other Health Care Provider Must Complete A or B

Vaccination Date: _____ Vaccine Type: MCV4 <input type="checkbox"/> MPSV4 <input type="checkbox"/>	
<p>PLEASE DO NOT SIGN THE COMPLIANCE FORM UNLESS THE STUDENT HAS PROPER VACCINES OR IMMUNE TESTS.</p> <p>_____ (Signature of Physician or Other Health Care Provider) _____ Date</p>	<p>Please print name, office address, phone number and the state where licensed and license number.</p>
<p>B: BACTERIAL MENINGITIS MEDICAL EXEMPTION</p> <p>IN THE OPINION OF THE PHYSICIAN, THE BACTERIAL MENINGITIS VACCINATION REQUIRED WOULD BE INJURIOUS TO THE HEALTH AND WELL-BEING OF THE STUDENT AND SHOULD NOT BE ADMINISTERED AT THIS TIME.</p> <p>_____ (Signature of Physician or Other Health Care Provider) _____ Date</p>	

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 student record.

Student's Signature - REQUIRED	Date
	

MINORS: Students under 18 Years of Age

Signature of Parent or Legal Guardian - REQUIRED if student is under 18 Years of Age		Date
		
Printed Name of Parent or Legal Guardian	Relationship to Student	