ALAMO COLLEGES BACTERIAL MENINGITIS VACCINATION COMPLIANCE FORM
PLEASE NOTE: STUDENTS WILL NOT BE ALLOWED TO COMPLETE THEIR REGISTRATION UNTIL THIS FORM HAS BEEN COMPLETED AND
ALL REQUIRED DOCUMENTATION HAS BEEN RECEIVED AND PROCESSED.

Email to: dst-bmeningitis@alamo.edu

E-fax to: (210) 486-9873

Mail to: San Antonio College in c/o Immunization Records Center 1300 San Pedro, Box 9999 San Antonio, TX 78212

Please use black or blue Ink

REQUIRED: STUDENT INFORMATION		
Last Name	First Name	MI Alamo Colleges' Student # (Banner #)
Date of Birth (MM/DD/YYYY)	Last four digits of Social Security #	Gender:
		☐ Male ☐ Female
Local Mailing Address:	Phone:	Primary College (choose one):
	()	☐ NLC ☐ NVC ☐ PAC
Street:	Alamo Colleges Email Address:	☐ SPC ☐ SAC
City:		
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COMPLETE EITHER OPTION 1 <u>OR</u> 2 OPTION 1: VACCINATION		
Select applicable documentation (DO NOT SEND YOUR ENTIRE MEDICAL HISTORY):		
I have included a copy of my official immunization record for the Bacterial Meningitis Immunization issued by a state or local health		
authority; OR		
I have included a copy of my official record from a Texas school official or a school official in another state; OR		
A licensed health care professional, authorize	zed by law to administer the required vacci	ne, has certified my immunization and has
completed the information below (additional documentation is not required).		
To be completed by <u>licensed health care profes</u>	sional: Vaccination Date:	
	Vaccine Type: MCV4 MF	PSV4 Brand Name:
I certify the above named student has received the		
Health Care Professional's Signature:	Printed Nam	a·
r roiceolonar e eignatare.	TIMOGRAM	Y•
Provider's Agency Name & Address:		Date:
Provider's Agency Name & Address:	OPTION 2: WAIVER	Date:
Select applicable waiver:	OPTION 2: WAIVER	
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Alamo Colleges Reserves the right to verify authenticity of submitted record.