Evidence of Vaccination against Bacterial Meningitis

Purpose of Form: This form may be used by any incoming student to Howard College in order to satisfy the requirement to submit evidence of a bacterial meningitis vaccination, in compliance with Texas Senate Bill 1107. The complete form can be hand delivered, mailed, faxed or emailed to the appropriate Howard College/SWCD campus.

Student Last Name: ___________________________ Student First Name: ___________________________
SS #: ___________________________ Date of Birth:___________________________________
Address: ______________________________________________________________________
Telephone Number: ___________________________ Preferred Email Address: ___________________________

Please read and place an “x” next to the section that applies, sign, date and submit to your campus registrar

☐ I have received the Bacterial Meningitis Vaccine and attached an official vaccination record.

☐ My physician or health care professional has documented my meningococcal vaccine at the bottom of this form.

- I understand that the vaccination must be administered 10 days prior to the start of classes.
- I understand that proof of the vaccination must include the physician or health care professional’s signature, the date the vaccination was administered, the medical facility’s stamp and seal, and contact information.
- I understand that I will not be allowed to register for courses at HC/SWCD without the Meningococcal Vaccine.

Student Signature: ___________________________________________ Date:__________________________

(Parent/Guardian if student is under 18 years of age)

Name of Administering Medical Facility:__________________________________________________________
Address:_________________________________________ Phone #:__________________________
Name of Administering/Verifying physician or health professional:_____________________________________

Type of vaccination:  ☐ MCV4  ☐ MPSV4

Date meningitis vaccination was administered:______________________________________________________

I hereby verify/confirm that the above named student received the mandated Bacterial Meningitis vaccine as required, and the information provided on this form is true and accurate.

Signature of physician/health care provider:_________________________________________ Date:__________________________

This section should be completed by a licensed Health Practitioner or Designee.

This section should be completed by the student

Place Official Stamp Here

Place Official Seal Here