Evidence of Vaccination against Bacterial Meningitis

TAMIU Student Health Services

Purpose of Form: This form may be used by any incoming student to Texas A&M International University in order to satisfy the requirement to submit evidence of a bacterial meningitis vaccination in compliance with Texas Senate Bill 1107.

The form may be hand-delivered (Student Center 125), mailed, faxed, or emailed to Student Health Services.

- TAMIU Student Health Services; Student Center 125; 5201 University Blvd; Laredo, TX 78041
- Fax: (956) 326-2235
- Email: vaccine@tamiu.edu

International Students: Complete this form and submit along with your original vaccine record.

Section A: This section should be completed by the student.

Last Name: _____ First Name: _____

Student ID #: A_____ Date of Birth: _____/_____/_____
Month Day Year

Telephone Number:_____ Email Address:_____

By signing this form, I certify that the information provided is true and accurate.

Student Signature: _____ ***Date***:_____/_____/_____
Month Day Year

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

Last name of the Health Practitioner who administered the vaccination:_____

First name of the Health Practitioner who administered the vaccination: _____

Date of the administration of the Bacterial Meningitis vaccine: _____/_____/_____
Month Day Year

By signing this form, I certify that the information provided is true and accurate. Specifically, I certify the following:

- I am a Health Practitioner authorized by law to administer an immunization or I have legal designation to complete and sign this form on behalf of a Health Practitioner authorized by law to administer an immunization.
- The individual who administered the bacterial meningitis vaccination to the student named above is or was a Health Practitioner authorized by law to administer an immunization.
- The bacterial meningitis vaccination was administered to the student named above by the Health Practitioner named above and on the date provided above.

Health Practitioner or Designee Signature:_____ ***Date***:_____/_____/_____
Month Day Year

License Number: _____ Country (if other than USA):_____

Phone Number: _____ Organization/Facility: _____

SHS-F3
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