

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			
UNT Student ID # _____	Enrollment Term (Check One) <input type="checkbox"/> Fall <input type="checkbox"/> Summer: 3 Week/5 Week 1/10 Week <input type="checkbox"/> Spring <input type="checkbox"/> Summer: 5 Week 2		Year _____
Last Name _____	First Name _____	MI _____	
Mailing Address _____		Apartment # _____	Daytime Phone # (____) ____ - _____
City _____		State _____	Zip Code _____
Date of Birth ____/____/____	Age _____	Email Address _____	

PLEASE COMPLETE ONE OF THE FOLLOWING TWO OPTIONS

<input type="checkbox"/> OPTION 1: Select type of attachment (Documentation must be in English or accompanied by a notarized translation.)	
<input type="checkbox"/> Official copy of immunization record stating the type of vaccine administered and signed by a Health Care Provider <input type="checkbox"/> Medical Exemption affidavit or certificate <input type="checkbox"/> Texas Department of State Health Services Conscientious Exemption form <input type="checkbox"/> Official immunization records generated by a state or local health authority <input type="checkbox"/> Official immunization record received from school officials, including a record from another state	
<input type="checkbox"/> OPTION 2: To be completed by a Health Care Provider - USE BLACK INK	
Date of Immunization (See paragraph 3 of page 1) ____/____/____	Official Stamp: Health Care Provider's Name, Address, Phone Number
Vaccine Administered <input type="checkbox"/> MCV4/Menactra <input type="checkbox"/> MPSV4/Menomune	
Signature and Title of Health Care Provider	Date ____/____/____

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 ____/____/____
MINORS: Students under 18 Years of Age		
Signature of Parent or Guardian– USE BLACK INK ONLY		Date ____/____/____
Full Name of Parent or Legal Guardian _____	Relationship to Student _____	

Office Use Only

Date Received ____/____/____	<input type="checkbox"/> Accepted <input type="checkbox"/> Denied <input type="checkbox"/> Incomplete	Date Completed ____/____/____ Completed By _____
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