

Bacterial Meningitis Vaccination Verification Form

(For New and Returning Students under the Age of 30)

Student Name: _____ BC ID: _____

Home Address: _____

Telephone #: _____ Email: _____

Please read and place an "X" next to the section that applies, sign, date, and submit to your Brazosport College 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 at least 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 or seal, and contact information.
- I understand that I will not be allowed to register for courses at BC without the Meningococcal Vaccine.

Student Signature: _____ Date: _____

Vaccine Verification and Medical Facility Information

(Completed by Physician/Health Professional)

Name of Administering Medical Facility: _____

Address: _____ Phone #: _____

Name of Administering/Verifying physician or health professional: _____

Type of Vaccination: MCV4 MPSV4 Other: _____

Date meningitis vaccination was administered: _____

Note: Vaccine must be proven effective against Bacterial Meningitis and must be approved by Center for Disease Control (CDC). Please visit: www.cdc.gov/meningitis/vaccine-info.html

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

Physician/Health Care Professional Signature: _____

Date: _____