Dallas County
Community College District

Bacterial Meningitis Vaccination Verification Form

Student Name:		DCCCD ID:	
Address:		Date of Birth:	
Telephone:		Email Address:	

Please read and place an "X" next to the section that applies, sign, date, and submit to your DCCCD Campus Registrar by mail, fax or in person.

☐I am declaring an exemption from the Texas immunization requirement for bacterial meningitis for reasons of conscience, and am attaching the appropriate notarized affidavit form.

- Texas Higher Education Coordinating Board (THECB) affidavit for students who are 18 years of age or older can be found at: http://www.thecb.state.tx.us/reports/PDF/2554.PDF?CFID=27957543&CFTOKEN=65832908
- Texas Department of State Health Services affidavit for students who are 17 years of age or younger can be found at: https://webds.dshs.state.tx.us/immco/default.aspx

☐I have received the Bacterial Meningitis Vaccine within the last 5 years and am attaching an ***official*** vaccination record in English or serologic test of immunity.

- The link to the DSHS immunization records is http://www.dshs.state.tx.us/immunize/immtrac/imm_providers.shtm

☐ 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 before I register for classes.**
- **I understand that I must obtain the bacterial meningitis vaccination at least 10 days before the first day of class.**
- **I understand that *I will not be allowed to register* for courses at DCCCD without the Meningococcal Vaccine.**
- **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.**

Student Signature:	Date:

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Vaccine Verification and Medical Facility Information (Completed by Physician/Health Professional – see page 2)

Name of Administering Medical Facility:	
Address:	Phone #:
Name of Administering/Verifying Physician or Healthcare 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: http://www.cdc.gov/meningococcal/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.

Signature of Physician/Healthcare Provider: Date:

Place Official Stamp Here

Place Official Seal Here