The Colleges of the Dallas County Community College District **11-18-16**

Brookhaven College
registrar-bhc@dcccd.edu
phone: 972-860-4883
fax: 972-860-4886

Cedar Valley College
registrar-cvc@dcccd.edu
phone: 972-860-0805
fax: 972-860-8001

Eastfield College
registrar-efc@dcccd.edu
phone: 972-860-8357
fax: 972-860-8306

El Centro College
registrar-ecc@dcccd.edu
phone: 214-860-2311
fax: 214-860-2233

Mountain View College
registrar-mvc@dcccd.edu
phone: 214-860-8600
fax: 972-698-3074

North Lake College
registrar-nlc@dcccd.edu
phone: 972-273-3183
fax: 972-273-3112

Richland College
registrar-rlc@dcccd.edu
phone: 972-238-6948
fax: 972-238-6346

Distance Learning students contact: Dallas Colleges Online, registrar-dtc@dcccd.edu, phone: 972-669-6400, fax: 972-669-6409

Proof of Bacterial Meningitis Immunization Compliance

The Age Requirement For New and Returning Students is under the Age of 22			
Student Name:		DCCCD ID#:	
Address:		Date of Birth:	
Email Address:		Telephone:	

Please read and place an "X" in the correct box: sign, date, and submit to your College Admissions Office.

☐ I am claiming a Bacterial Meningitis Vaccine exemption due to health reasons (see section B below).

☐ I am declaring an exemption from the Texas immunization requirement for bacterial meningitis for reasons of conscience, and have attached the appropriate affidavit form. Texas Department of State Health Services (DSHS) affidavit can be found at https://corequestjc.dshs.texas.gov/

☐ I have received the Bacterial Meningitis Vaccine within the last 5 years and I have attached an ***official*** vaccination record.

☐ My Physician or health care professional has documented my meningococcal vaccine in section A below.

Physician or Other Health Care Provider Must Complete A or B

A. Vaccination Date: _____ Vaccine Type: MCV-4 ☐ MPSV-4 ☐ As recommended by the CDC

PLEASE DO NOT SIGN THE COMPLIANCE FORM UNLESS THE STUDENT HAS PROPER VACCINES OR IMMUNE TESTS.

_____ _____

(Signature of Physician or Other Health Care Provider) Date

NOTE: The only two vaccines approved at this time are MCV4 (Menveo) and MPSV4 (Menactra). The Meningitis B (MenB) vaccine is not required and will not fulfill your meningitis documentation requirement at this time.

Please use stamp or print name, office address, phone number and the state where licensed and license number.

B. BACTERIAL MENINGITIS MEDICAL EXEMPTION

I CERTIFY, THAT IN MY OPINION, THE BACTERIAL MENINGITIS VACCINATION REQUIRED WOULD BE INJURIOUS TO THE HEALTH AND WELL-BEING OF THE STUDENT AND SHOULD NOT BE ADMINISTERED AT THIS TIME.

_____ _____

(Signature of Physician or Other Health Care Provider) Date

- ✓ I understand that I will not be allowed to register for courses in any of the colleges of the DCCCD without the proper meningitis vaccination documentation as indicated above.
- ✓ 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 certify that, to the best of my knowledge, the above information (including attachments) is true and correct. I also give my consent for the above immunization record to be entered into my student record.

Student's Signature – ***REQUIRED***	Date
MINORS: **Signature of Parent or Legal Guardian** ***Required*** if student is under 18 Years of Age	Date
Printed Name of Parent or Legal Guardian	Relationship to Student