Received _____

Entered _____

Scanned _____

Office Use Only

Evidence of Vaccination against Bacterial Meningitis

Purpose of Form: This form will be used by an entering or returning student to Sam Houston State University in order to satisfy the requirement to submit evidence of vaccination against bacterial meningitis, in compliance with SB 1107, 82nd R. This requirement MUST be completed before registering for classes and/or securing housing on campus. The completed form shall be received by email (shc@shsu.edu), fax (936-294-2304) or mail (Vaccination Processing, Student Health Center, Box 2358, Huntsville, TX 77341-2358).

STUDENT SECTION to be completed by the student. Please print legibly.

Please check your entering semester at SHSU:

Summer ☐

Fall ☐

Spring ☐

Student Last Name: _____ Student First Name: _____

Sam ID#: _____ Date of Birth: _____/_____/_____
Month Day Year

Telephone #: _____ SHSU Username: _____

By signing this form, I certify that the information provided is true and accurate and I understand the rules and regulations concerning the bacterial meningitis vaccination requirement.

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

HEALTH PRACTITIONER SECTION to be completed by a licensed Health Practitioner or Designee.

I certify that _____ received the Bacterial Meningitis Vaccination, which
Patient Name

was administered by me or my office on _____.
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 _____

Name and Address of Facility or Clinic:_____

_____