



CLARENDON COLLEGE

Clarendon College Evidence of Vaccination against Bacterial Meningitis

Under the requirements of a new law recently enacted by the Texas State Legislature, students who are under 22 years of age and entering higher education must demonstrate proof of vaccination against bacterial meningitis.

This section should be completed by the student

Last Name: _____ First Name: _____ SSN: ____ - ____ - ____

Date of Birth: ____ / ____ / ____ Phone Number: _____ Email address: _____

By signing this form, I certify that the information provided is true and accurate; I understand the rules and regulations concerning the bacterial meningitis vaccination requirement for students on campus; and agree to the following:

- I must supply evidence of a bacterial meningitis vaccination, or booster dose, during the five-year period prior to registering.
- I must obtain the bacterial meningitis vaccination at least 10 days before arriving on campus.
- If I obtain the bacterial meningitis vaccination less than 10 days prior to arriving on campus, I will be unable to register until proof of vaccination is on file.

Student's Signature: _____ Date: ____ / ____ / ____

This section should be completed by a licensed Health Practitioner/Designee who administered the vaccination

Date of the administration of the bacterial meningitis vaccination: ____ / ____ / ____

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 below, on the date provided above.

Health Practitioner's Name (Print): _____

Health Practitioner or Designee's Signature: _____ Date: ____ / ____ / ____

Healthcare Facility & Address: _____

Exemptions Allowed by Law

- An affidavit or a certificate signed by a physician who is duly registered and licensed to practice medicine in the United States in which it is stated that, in the physician's opinion, the vaccination required would be injurious to the health and well-being of the student; or
- A notarized conscientious exemption form from the Texas Department of State Health Services, <https://co-request-jc.dshs.texas.gov/>.