

## Bacterial Meningitis Evidence of Vaccination or Medical Exemption

**Purpose of Form:** This form may be used by any incoming student to Lamar Institute of Technology in order to satisfy the requirement to submit evidence of a bacterial meningitis vaccination, in compliance with Texas Senate Bill 1107. The complete form can be hand-delivered, mailed, faxed, or emailed to the Student Services Office: P.O. Box 10043 Beaumont, TX 77710, Fax: (409) 813-1844, Email: [immunization@lit.edu](mailto:immunization@lit.edu)

<b>This section should be completed by the student</b>
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Student Last Name: \_\_\_\_\_ Student First Name: \_\_\_\_\_

Student ID Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Telephone Number: \_\_\_\_\_ LIT Email Address: \_\_\_\_\_

First Semester at Lamar Institute of Technology (Select one and indicate the appropriate year):

Spring, Year: \_\_\_\_\_  Summer, Year: \_\_\_\_\_  Fall, Year: \_\_\_\_\_

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

<b>This section should be completed by a licensed Health Practitioner or Designee</b>
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Last/Family Name of the Health Practitioner who administered the vaccination: \_\_\_\_\_

First/Given Name of the Health Practitioner who administered the vaccination: \_\_\_\_\_

Date of the administration of the bacterial meningitis vaccination: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Last/Family Name of the vaccination recipient (i.e. the student): \_\_\_\_\_

First/Given Name of the vaccination recipient (i.e. the student): \_\_\_\_\_

Date of birth of the vaccination recipient (i.e. the student): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
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.

**OR:** The student has not been immunized against Bacterial Meningitis based on the conclusion at this time that it would be injurious to the student's health.

Comments \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Health Practitioner or Designee Signature: \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

License Number: \_\_\_\_\_ Phone: \_\_\_\_\_

Address of Medical Facility: \_\_\_\_\_