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

This section should be completed by the student

Student Last Name: ________________________________________       Student First Name: __________________________________________
Student ID Number: ______________________________________      Date of Birth: ________________/ _______/ ________
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 _____________ / _______ / ________

This section should be completed by a licensed Health Practitioner or Designee

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: __________________ / _______/ ________
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): __________________ / _______/ ________
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 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 ____________/ _____/ _____
License Number: ______________________________________  Phone: ______________________________
Address of Medical Facility: __________________________________________________________________________