TCU STUDENT AFFAIRS | Brown-Lupton Health Center

Mandatory Bacterial Meningitis Vaccination Form

(**ONLY THIS FORM** will be accepted as proof of vaccination)

Student's Name:_____ TCU ID:_____

Date of Birth_____ Term Enrolling: Fall Spring Summer Year:_____ Current Email_____

MENINGITIS DOCUMENTATION

Home Address:_____

Telephone #:_____(Home) _____(Cell)

Please Initial next to each statement indicating that you understand the following

_____ I understand that I *will not be allowed to register* for courses at TCU without the Meningococcal Vaccine.
_____ I understand that the vaccination must be administered at least 10 days prior to moving into campus housing
_____ 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 contact information.

My Physician or Health Care Professional has documented my meningococcal vaccine at the bottom of this form.

Student Signature:_____ Date:_____

Vaccine Verification and Medical Facility Information (Completed by Physician/Health Professional)
Meningitis Immunization must be within the past 5-year period preceding the first day of the semester.

Name of Administering Medical Facility:_____

Address:_____ Phone #:_____

Name of Administering/Verifying physician or health professional:_____

Type of Vaccination: ☐ MCV4 ☐ MPSV4 ☐ Other:_____

Date meningitis vaccination was administered:_____

Note: **Vaccine must be proven effective against Bacterial Meningitis and must be approved by Center for Disease Control (CDC). Please visit: www.cdc.gov/meningitis/vaccine-info.html**

I hereby verify/confirm that the above named student received the mandated Bacterial Meningitis vaccine as required.

Place Official Stamp Here	_____	_____
	Health Professional Signature	**Date:**