

**Alvin College**  
**Evidence of Vaccination for Bacterial Meningitis**

**Purpose of Form:** This form may be used by any student who is required to satisfy the requirement to submit evidence of a bacterial meningitis vaccination in compliance with Texas Education Code 51.9191/51.9192 *et seq.* and THECB Rule 21.610 *et seq.*

**How to Submit Evidence of Vaccination:** Attach official documentation in addition to this form, if available.

**In person:** Alvin College Admissions/Welcome Center

**Email:** Record scanned and emailed to: [admissions@alvincollege.edu](mailto:admissions@alvincollege.edu)

**SECTION A.** This section must be completed by the student.

Student Name: \_\_\_\_\_

Student ID: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

First Semester at Alvin Community College (Select one and indicate the appropriate year):

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

**I certify that the information provided is true and accurate. I acknowledge receiving information from the college about the bacterial meningitis vaccination requirement. The vaccination or booster is not more than 5 years old as of the first day of the term in which I plan to enroll.**

Student Signature: \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**SECTION B.** This section must be completed by a licensed Health Practitioner or Designee.

Vaccine administered: ☐ MCV-4 (Menactra) ☐ MPSV-4 (Menomune or Menveo)

Name of the Health Practitioner who administered the vaccination:

\_\_\_\_\_

Date of the administration of the bacterial meningitis vaccination: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name of the vaccination recipient \_\_\_\_\_

Date of birth of the vaccination recipient \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**By signing this form, I certify that the information provided is true and accurate:**

- 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 \_\_\_\_\_

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