Evidence of Vaccination against Bacterial Meningitis
TAMIU Student Health Services

Purpose of Form: This form may be used by any incoming student to Texas A&M International University in order to satisfy the requirement to submit evidence of a bacterial meningitis vaccination in compliance with Texas Senate Bill 1107.

The form may be hand-delivered (Student Center 125), mailed, faxed, or emailed to Student Health Services.
- TAMIU Student Health Services; Student Center 125; 5201 University Blvd; Laredo, TX 78041
- Fax: (956) 326-2235
- Email: vaccine@tamiu.edu

International Students: Complete this form and submit along with your original vaccine record.

Section A: This section should be completed by the student.

Last Name: ______________________________ First Name: ____________________________
Student ID #: A_________________________ Date of Birth: _______/_____/_____
Telephone Number:_______________________ Email Address:_____________________

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

Student Signature: ___________________________ Date:_______/_____/_____

Section B: This section should be completed by a licensed Health Practitioner or Designee.

Last name of the Health Practitioner who administered the vaccination:__________________________
First name of the Health Practitioner who administered the vaccination:__________________________
Date of the administration of the Bacterial Meningitis vaccine: _______/_____/_____

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.

Health Practitioner or Designee Signature: ___________________________ Date:_______/_____/_____
License Number: ___________________________ Country (if other than USA):_____________________
Phone Number: ___________________________ Organization/Facility: ___________________________

SHS-F3
Update 03/11/14