Fax to: 281-283-2530 **Mail to:** University of Houston-Clear Lake, Office of Academic Records, 2700 Bay Area Blvd., Houston, TX 77058 or **Hand deliver to:** Student Assistance Center (SAC), Room 1102, Student Services & Classroom Building.

University of Houston Clear Lake

PROOF OF BACTERIAL MENINGITIS IMMUNIZATION COMPLIANCE

Please read the immunization requirements prior to completing this form.
ALL applicable sections should be completed prior to printing.

STUDENT INFORMATION

Student ID #	Date of Birth (MM/DD/YYYY)	Enrollment Term (Semester and Year)

Last Name	First Name	MI	Gender: ☐Male ☐Female

Mailing Address	Apartment #	Phone Number
City	State / Zip Code	

Student Status	Email Address
□ New to UHCL □ Returning-(Not enrolled for less than 1 year) □ Readmit-(Not enrolled for more than 1 year)	

SELECT OPTION 1 OR 2

OPTION 1: Select type of attachment

□ **A COPY of your official immunization record signed by a Health Care Provider**
Documentation must be in English or accompanied by a notarized translation

□ **Medical Exemption Affidavit or Certificate** (***The law requires that you visit a doctor in the U.S. to be able to get an exemption for medical reasons.)***

□ Texas Department of State Health Services Exemption Form **(*Exemption for reasons of conscience including religious beliefs.)***
Submit ORIGINAL only, a copy will not be accepted

OPTION 2: Physician or Other Health Care Provider Must Complete A or B

Vaccination Date: _____ _____ Vaccine Type: MCV4 □ MPSV4 □

PLEASE DO NOT SIGN THE COMPLIANCE FORM UNLESS THE STUDENT HAS PROPER VACCINES OR IMMUNE TESTS.

_____ _____
(Signature of Physician or Other Health Care Provider) Date

Please print name, office address, phone number and the state where licensed and license number.

B: BACTERIAL MENINGITIS MEDICAL EXEMPTION

IN THE OPINION OF THE PHYSICIAN, THE BACTERIAL MENINGITIS VACCINATION REQUIRED WOULD BE INJURIOUS TO THE HEALTH AND WELL-BEING OF THE STUDENT AND SHOULD NOT BE ADMINISTERED AT THIS TIME.

_____ _____
(Signature of Physician or Other Health Care Provider) Date

I have read and understand the Bacterial Meningitis Immunizations requirements. I certify that, to the best of my knowledge, the above information (including any attached copies) is true and correct. I also give my consent for the above immunization record to be entered into my student record.

Student's Signature - *REQUIRED*	**Date**

MINORS: Students under 18 Years of Age

Signature of Parent or Legal Guardian - *REQUIRED if student is under 18 Years of Age*	**Date**

Printed Name of Parent or Legal Guardian	Relationship to Student

Make a copy of your immunization documentation for your records.
The university does not provide copies of immunization record submissions.