

**Bacterial Meningitis Vaccination Verification Form**  
(For incoming new students under the age of 22)

Student Name: \_\_\_\_\_ SJC ID #: \_\_\_\_\_

Home Address: \_\_\_\_\_

Telephone#: \_\_\_\_\_ Email: \_\_\_\_\_

Please read and place an "X" next to the section that applies to you and include your signature and date. Submit completed form with health care provider's signature to the Office of Enrollment Services on any San Jacinto College campus, or fax it to 281-669-4720.

I have received the Bacterial Meningitis Vaccine and attached an official vaccination record.

My physician or health care professional has documented my meningococcal vaccine at the bottom of this form.

- I understand that the vaccination must be administered at least 10 days prior to the start of classes.
- 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 or seal, and contact information.

• I understand that I will not be allowed to register for courses at SJC without the **Meningococcal** vaccine.

Student signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Vaccine Verification and Medical Facility Information**  
(Completed by Physician/Health Professional)

Name of administering medical facility: \_\_\_\_\_

Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

Name of administering/verifying physician or health professional: \_\_\_\_\_

Type of vaccination:       MCV4       MPSV4       MenACWY: \_\_\_\_\_

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](http://www.cdc.gov/meningitis/vaccine-info.html). **MENB alone is not acceptable.**

I hereby verify/confirm that the above named student received the mandated Bacterial Meningitis vaccine as required, and that the information provided on this form is true and accurate.

Signature of physician/health care provider: \_\_\_\_\_ Date: \_\_\_\_\_

Central Campus: 8060 Spencer Highway, Pasadena, Texas 77505  
North Campus: 5800 Uvalde Road, Houston, Texas 77049  
South Campus: 13735 Beamer Road, Houston, Texas 77089  
Fax: 281-669-4720  
Email: [Meningitis.Docs@sjcd.edu](mailto:Meningitis.Docs@sjcd.edu)

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