Student Health Center
SAM HOUSTON STATE UNIVERSITY

936-294-1805 **shc@shsu.edu**

Evidence of Vaccination - Bacterial Meningitis

Upon completion: **upload in the Forms and Clearances Tab in your Patient Portal *kathealth.shsu.edu***

STUDENT INFORMATION SECTION MUST BE COMPLETED. *Please print legibly*.

Please check your entering semester at SHSU:
Summer ☐
Fall ☐
Spring ☐

Student Last Name:_____ Student First Name: _____

Sam ID#:_____ Date of Birth:_____/_____/_____
Month Day Year

Telephone #:_____

**By signing this form, I certify that the information provided is true and accurate and I understand the rules and regulations concerning the bacterial meningitis vaccination requirement.

Student Signature:_____ Date:_____/_____/_____
Month Day Year

HEALTH PRACTITIONER SECTION to be completed by a licensed Health Practitioner or Designee

I certify that_____ (Patient Name)

Received the **MCV 4** Bacterial Meningitis Vaccination (Brand Names: Menveo, Menactra, Menomune)

And it was administered by me or my office on_____(Date)

Clinic/Facility Name:
_____

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
- I have legal designation to complete and sign this form on behalf of a Health Practitioner authorized by law to administer an immunization.

Provider Signature _____ Date: _____

This form will be used by an entering or returning student to Sam Houston State University to satisfy the requirement to submit evidence of vaccination against bacterial meningitis, in compliance with SB 1107, 82ndR