Evidence of Vaccination against Bacterial Meningitis

Purpose of Form: This form may be used by any incoming student to Texas A&M University at Galveston to satisfy the requirement to submit evidence of a bacterial meningitis vaccination. The complete form can be uploaded via the Applicant Information System or it may be hand-delivered, mailed, faxed or emailed to:
Enrollment Services, Texas A&M University at Galveston, P.O. Box 1675, Galveston, TX 77553-1675.
FAX 409.740.4731, Email: admissions@tamug.edu.

This section should be completed by the student:
Student Last Name: _____________________ Student First Name: _____________________________
UIN: __________________________ Date of Birth: ________ / ______ / _______
Cell Phone Number: _________________ Preferred Email Address: ____________________________
First Semester at Texas A&M University at Galveston (Select one and indicate the appropriate year):
□ Spring, Year: _______ □ Summer, Year: _______ □ Fall, Year: ________

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 _____/ ___ / _____

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 vaccination: ______ / ____ / _____
Name of the vaccination recipient (i.e. the student):
________________________________________________________ __________________
First Name  Last Name
Date of birth of the vaccination recipient (i.e. the student): _____/  ______ / _____

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: _______________________ Phone:__________________________________

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