LAMAR INSTITUTE OF TECHNOLOGY

Bacterial Meningitis Evidence of Vaccination or Medical Exemption

Purpose of Form: This form may be used by any incoming student to Lamar Institute of Technology in order to satisfy the requirement to submit evidence of a bacterial meningitis vaccination, in compliance with Texas Senate Bill 1107. The complete form can be hand-delivered, mailed, faxed, or emailed to the Student Services Office: P.O. Box 10043 Beaumont, TX 77710, Fax: (409) 813-1844, Email: immunization@lit.edu

This section should be completed by the student

Student Last Name: _____ Student First Name: _____

Student ID Number: _____ Date of Birth: _____ / _____ / _____
Month Day Year

Telephone Number: _____ LIT Email Address: _____

First Semester at Lamar Institute of Technology (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 _____ / _____ / _____
Month Day Year

This section should be completed by a licensed Health Practitioner or Designee

Last/Family Name of the Health Practitioner who administered the vaccination: _____

First/Given Name of the Health Practitioner who administered the vaccination: _____

Date of the administration of the bacterial meningitis vaccination: _____ / _____ / _____
Month Day Year

Last/Family Name of the vaccination recipient (i.e. the student): _____

First/Given Name of the vaccination recipient (i.e. the student): _____

Date of birth of the vaccination recipient (i.e. the student): _____ / _____ / _____
Month Day Year

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.

OR: The student has not been immunized against Bacterial Meningitis based on the conclusion at this time that it would be injurious to the student's health.
Comments_____
_____
_____

Health Practitioner or Designee Signature: _____ Date _____ / _____ / _____
Month Day Year

License Number: _____ Phone: _____

Address of Medical Facility: _____