Fax to: 713-743-8336 **Mail This Form to:** University of Houston, Office of Admissions, Welcome Center, 4400 University Drive, Houston, TX 77204-2023
Email This Form to: immunization@uh.edu or **Hand Deliver to:** UH Main Campus, Welcome Center, Building 553, http://www.uh.edu/maps/building/WC

UNIVERSITY of HOUSTON

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

University of Houston ID # (*myUH 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 UH ☐ 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** (*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

A: Vaccination Date: _____ _____ Vaccine Type: MCV4 ☐ MPSV4 ☐ As recommended by the CDC
http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-mening.pdf

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 Immunization 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.