Evidence of Vaccination against Bacterial Meningitis

Purpose of Form: This form may be used by any incoming student to Texas A&M University-San Antonio (TAMU-SA) in order to satisfy the requirement to submit evidence of a bacterial meningitis vaccination, in compliance with Texas Senate Bill 1107. TAMU-SA has chosen the services of Magnus Health SMR (Student Medical Record) to provide web-based submission. There is a $10 surcharge to submit this form, students will be prompted to provide a credit card when they upload the document. Once the documentation has been verified and approved by Magnus Health SMR, the university will lift the registration hold.

This section should be completed by the student

Student Last Name: ___________________________ Student First Name: ___________________________

K Number: ___________________________ Date of Birth: _______/_____/______

Month Day Year

Telephone Number: ___________________________ Preferred Email Address: ___________________________

First Semester at Texas A&M University (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.

Health Practitioner or Designee Signature: ___________________________ Date _______/_____/______

Month Day Year

License Number: ___________________________ Phone: ___________________________

Office Use Only
Received Hold Removed