SOUTH PLAINS COLLEGE

Evidence of Bacterial Meningitis Vaccination/ 100% Online Exemption Form

The State of Texas requires all entering students who are under the age of 22 by the official first class day of the semester to provide proof that the meningitis vaccination was administered at least 10 days prior to the first day of the term. Vaccinations must have been received or renewed within the last 5 years. **Proof of vaccination or exemption must be received by the Admissions and Records Office before the student will be allowed to register for classes.** To submit this form:

Mail to:
South Plains College
Admissions and Records Office, Box C
1401 S. College Ave.
Levelland, TX 79336

Email to:
admissions@southplainscollege.edu

Hand Deliver to:
Admissions and Records Office
Levelland Campus
Student Services Building
1401 S. College Avenue
Levelland, Texas 79336

or

Admissions and Records Office
Reese Center
SPC Building 8
819 Gilbert Drive
Lubbock, Texas

This section must be completed by the student. Please type in form, print, and sign before submission.

Name: _____ DOB: _____ Student ID: _____
Last, First M — Month / Day / Year

Phone Number: _____ Email Address: _____

☐ I have received the Bacterial Meningitis Vaccine and my physician or health care professional has documented my meningococcal vaccine on this form. I understand that proof of the vaccination **must include** the date the vaccination was administered, the medical facility's contact information, the physician's or health care professional's signature, and the medical facility's stamp and/or seal.

☐ I am enrolling in **ONLY** 100% online courses or other distance education courses that do not require me to take a proctored exam on campus. I understand and acknowledge that this is a temporary waiver valid for **ONLY** the semester and year indicated below. Select ONLY one semester per form.

Year: _____ ☐ Fall ☐ Spring ☐ Summer I ☐ Summer II ☐ Winter Interim ☐ Spring Interim

Student Signature: _____ **Date:** _____

This section must be completed by a licensed Health Practitioner/Designee who administered the vaccination. Please print, sign, and place official stamp or seal in designated area.

Name of Administering Medical Facility: _____

Address: _____ Phone #: _____

Name of Administering/Verifying physician or health professional: _____

Type of vaccination: ☐ **MCV4** ☐ **MPSV4**

Date meningitis vaccination was administered: _____
Month / Day / Year

I hereby verify/confirm that the above named student received the mandated Bacterial Meningitis vaccine as required, and the information provided on this form is true and accurate.

Official Stamp and/or Seal must be applied here

Signature of physician/health care provider: _____ Date: _____