Wharton County Junior College

Bacterial Meningitis Vaccination Record

Students must read all bacterial meningitis vaccination requirements prior to completing this form. The completed form must be returned to WCJC Office of Admission and Registration at any campus (see below for contact information)

Student Information			
WCJC Student I.D.	Date of Birth (MM/DD/YYYY)		Enrollment Term (Semester and Year)
Last Name	First Name	MI	Gender
Student e-Mail Address			Phone Number

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.	Date of Vaccination
☐ Medical Exemption Affidavit or Certificate *(Submit ORIGINAL only, a copy is not acceptable)*	
☐ Exemption from Immunizations for Reasons of Conscience Affidavit Form*(submit ORIGINAL)*	

Option 2: To be completed by a Health Care Provider		
Date of Vaccination: ____/____/____ DD YYYY MM Vaccine Administered: ☐ MCV4 ☐ MPSV4 B	Office Stamp: Health Care Provider's Name, Address, Phone	
	Signature of Health Care Provider	Date

I have read and understand the bacterial meningitis vaccination 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 electronic student record.

Student Signature- REQUIRED *Date*

Minors: Students under 18 Years of Age

Signature of Parent or Legal Guardian- REQUIRED *Date*

Printed Name of Parent or Legal Guardian Relationship to Student

QUESTIONS: Return forms by fax to 979-532-6494, by email to registrar@wcjc.edu, or by hand delivery to any WCJC campus Office of Admission and Registration.

Make a copy of your immunization documentation for your records. WCJC does not provide copies of immunization record submissions.