Wharton County Junior College

Bacterial Meningitis Vaccination Record

WCJC Student ID | Last Name (Current Legal) | First Name | MI

Date of Birth (MM/DD/YY) | Enrollment Term (Semester, Year)

Email Address | Preferred Phone Number

Select Option 1 or Option 2

Option 1: Verification Document (Document must be attached to this form.)

☐ Official immunization record signed by a healthcare provider. Document must be in English or accompanied by a notarized translation. Date of vaccination: _____

☐ Medical Exemption Affidavit or Certificate (Submit original only.)

☐ Exemption for Immunization for Reasons of Conscience Affidavit (Submit original only.)

Option 2: Verification to be completed by a Healthcare Provider

Date of Vaccination: _____/_____/_____ MM DD YYYY	Office Stamp: Healthcare Provider Name, Address, Phone	
Vaccine Administered: ☐ MCV4 ☐ MPSV4 ☐ B	Signature of Healthcare 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 all attachments) is true and correct. I also give my consent for the above immunization record to be entered into my electronic student record.

Student Signature (For electronic submission, type your name and WCJC student ID.) | Date

Parent/Guardian Signature (If student is under 18 years of age. For electronic submission, type your name and student's WCJC ID.) | Date

Email completed form to registrar@wcjc.edu. Make a copy of your immunization documentation for your records. WCJC does not provide copies of immunization record submissions.

Office Use Only Revised: 03/19/2020

Processed by: _____ Term Code: _____