



Bacterial Meningitis Vaccination Verification Form
(For New and Returning Students Under the Age of 22)

Student Name: _____ TCC ID: _____

Home Address: _____

Telephone #: _____ TCC E-mail: _____@my.tccd.edu

Please read and select the section that applies. Sign, date and submit to your Admissions and Registrar's Office.

- I have received the Bacterial Meningitis vaccine and attached an official vaccination record.
- My physician or health care professional has documented my meningococcal vaccine at the bottom of this form.
- I understand the vaccination must be administered at least 10 days prior to the start of classes.
- I understand proof of the vaccination must include the physician or health care professional's signature, the date the vaccination was administered, the medical facility's stamp or seal and contact information.
- I understand I will not be allowed to register for courses at TCC without the meningococcal vaccine.

Student Signature: _____ Date: _____

Vaccine Verification and Medical Facility Information (Completed by Physician/Health Professional)

Name of Administering Medical Facility: _____

Address: _____ Phone: _____

Name of Administering/Verifying physician or health professional: _____

Type of Vaccination: MCV4 MPSV4 MenB Other _____

Date meningitis vaccination was administered: _____

Note: Vaccine must be proven effective against Bacterial Meningitis and must be approved by the Center for Disease Control (CDC). Please visit: <https://www.cdc.gov/vaccines/vpd/mening/index.html>

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

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

Place Official Stamp Here

<https://www.tccd.edu/admission/meningitis-vaccinations/>

Tarrant County College is an Equal Opportunity institution/equal access to the disabled.

Place Official Seal Here