ANGELO STATE UNIVERSITY
OFFICE OF THE REGISTRAR
registrar@angelo.edu
(325) 942-2043 | Fax: 325-942-2553
ASU Station #10898 • San Angelo, TX 76909-0898

MEMBER, TEXAS TECH UNIVERSITY SYSTEM

EVIDENCE OF VACCINATION AGAINST BACTERIAL MENINGITIS

Purpose of Form: This form may be used by any incoming student to Angelo State University in order to satisfy the requirement to submit evidence of a bacterial meningitis vaccination, in compliance with Texas Senate Bill 1107. The complete form can be hand-delivered, mailed, faxed or e-mailed to the Office of the Registrar, ASU Station #10898 San Angelo, TX 76909-0898, Phone: 325-942-2043, Fax: 325-942-2553, E-mail: meningitis@angelo.edu.

THIS SECTION SHOULD BE COMPLETED BY THE STUDENT

Student Last Name: _____ Student First Name: _____

CID: _____ Date of Birth: _____ / _____ / _____
Month Day Year

Telephone Number: _____ Preferred E-mail Address: _____

First Semester at Angelo State 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 name of the health practitioner who administered the vaccination: _____

First name of the health practitioner who administered the vaccination: _____

Date of the administration of the bacterial meningitis vaccination: _____ / _____ / _____
Month Day Year

Last name of the vaccination recipient (i.e., the student): _____

First 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: _____