

## **Bacterial Meningitis Vaccination Verification Form**

Last Name  Date of Birth		First Name	HCC Student ID Number
		Daytime phone #	Email address
I am submi	tting meningitis imn	nunization documentation	n as required
stating tha	t the vaccine poses condition, the exen	a significant risk to your h	te (Signed statement by physician ealth. Unless statement indicates for only one year from the date signed
I am submi		r Exemption from Immuniz	zation for Bacterial Meningitis for Reasons
		ENTATION MAY BE SUBI	MITTED:
<ul><li>AT ANY CA</li><li>BY EMAIL:</li></ul>		ntation and attach it to an	email sent to vaccine@hccs.edu
• BY FAX:	713/718-2882		
BY U.S. MA	IL:		
Houston Co	mmunity College		
	& Records,		
P.O. Box 66	•		
Houston, To	exas 77266-7517		
	derstand the Bacteri provided is true and	-	on requirement. I certify that the
Student Signature			ate