UNIVERSITY OF TEXAS ARLINGTON

The University of Texas at Arlington
Office of Admissions, Records and Registration
701 South Nedderman Drive
Davis Hall Room 129
Arlington, TX 76019
www.uta.edu/records

Bacterial Meningitis Immunization Record

Student Information

Enrollment Term Year: ☐ Fall ☐ Spring ☐ Summer	Please read the immunization requirements prior to completing this form. All applicable sections should be completed online prior to printing.		
UTA Student ID #	Last Name:	First Name:	MI:
Mailing Address:		Apt #	
City:	State: Select	Zip Code:	
Email Address:	Date of Birth:		

To Be Completed by Health Care Provider

Official Stamp: Health Care Provider's Name, Address and Phone Number	
Is this a medical exemption? If so, Please provide an explanation below.	
Date of Immunization:	
Signature and Title of Health Care Provider	Date:

I have read and understand the Bacterial Meningitis immunizations requirements. I certify that, to the best of my knowledge, the above information (including any attached copies) is true and correct.

Signature	Date:

MINORS: Students Under 18 Years of Age

Full Name of Parent or Legal Guardian	Relationship to Student:
Signature of Parent or Guardian	Date:

OFFICE USE ONLY

Date Received:	Status: Complete Incomplete Rejected	Completed By:	Date Completed: