Bacterial Meningitis Immunization Form

Please submit this form to your doctor for signature, OR if you are submitting a vaccination record from your doctor, please use this form as a cover letter.

______________________________	________________________	______/_______/_______
Student Last Name	Student First Name	Date of Birth

900________________	_____________________@udallas.edu	_______-_______-_______
Student ID#	Student Email Address	Student Phone Number

Return completed form/documentation to:
University of Dallas
School of Ministry Admissions Office
1845 E. Northgate Drive
Irving, TX 75062
Fax: 972-721-4009

Vaccination Information

Please check the type of vaccine that was administered: _______/________/_________

Date Vaccine Administered

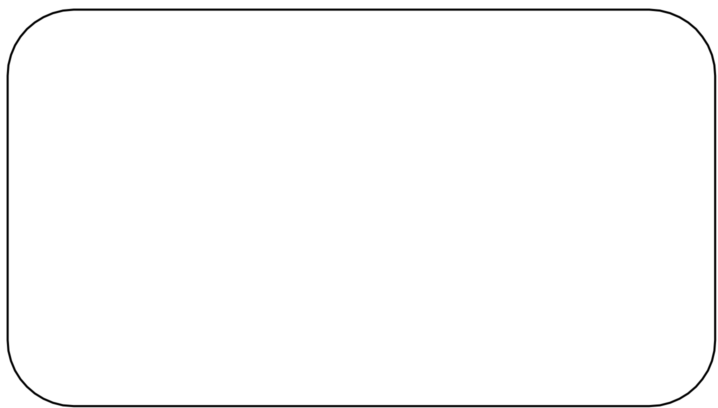
- ☐ Meningococcal Conjugate Vaccine (MCV4)
- ☐ Meningococcal Polysaccharide Vaccine (MPSV4)
- ☐ Other, please specify: ____

____
Physician Printed Name

____
Physician Signature

__________/__________/__________
Date Signed

____
Practice/Hospital Name



Physician/Practice Stamp

- Vaccine information must be in English.
- An immunization record issued by a state or local health authority or other school officials will be accepted.
- Vaccine must be administered during the five-year period preceding, or at least 10 days prior to, the first day of class.