## The Colleges of the Dallas County Community College District

Cedar Valley CollegeEastfileregistrar-cvc@dcccd.eduregistraphone: 972-860-8201phonefax: 972-860-8001fax: 97

 Eastfield College
 E

 registrar-efc@dcccd.edu
 registrar-gfc@dccd.edu
 registrar-gfc@dccd.edu

 phone: 972-860-7167
 p

 fax: 972-860-8306
 fax

El Centro College registrar-ecc@dcccd.edu phone: 214-860-2311 fax: 214-860-2233 Mountain View College registrar-mvc@dcccd.edu phone: 214-860-8600 fax: 972-698-3074

North Lake College <u>registrar-nlc@dcccd.edu</u> phone: 972-273-3183 fax: 972-273-3112 Richland College registrar-rlc@dcccd.edu phone: 972-238-6100 fax: 972-238-6346

Distance Learning students contact: Dallas Colleges Online, registrar-dtc@dcccd.edu, phone: 972-669-6414, fax: 972-682-7071

## **Proof of Bacterial Meningitis Immunization Compliance**

		uirement For Ne				
Student Name:			DCCCD IE	D#:		
Address:			Date of Bi	rth:		
Email Address:			Telephone	e:		
** Effective January 1, 2014, the age for an exemption from the vaccine requirement will change from 30 to 22.						
<ul> <li>Please read and place an "X" in the correct box: sign, date, and submit to your College Admissions Office.</li> <li>I am claiming a Bacterial Meningitis Vaccine exemption due to health reasons (see section B below).</li> <li>I am declaring an exemption from the Texas immunization requirement for bacterial meningitis for reasons of conscience, and have attached the appropriate affidavit form. Texas Department of State Health Services (DSHS) affidavit can be found at <a href="https://webds.dshs.state.tx.us/immcojc/Default.aspx">https://webds.dshs.state.tx.us/immcojc/Default.aspx</a>.</li> <li>I have received the Bacterial Meningitis Vaccine within the last 5 years and I have <u>attached</u> an official vaccination record.</li> <li>My Physician or health care professional has documented my meningococcal vaccine in section A below.</li> </ul>						
My Physician						
	Physician or Other I	Health Care Pro	vider Must Co	omplete A or	В	
My Physician A. Vaccination D	Physician or Other I		vider Must Co			
A. Vaccination D PLEASE DO NOT SIG VACCINES OR IMML	Physician or Other I ate:	Health Care Pro	MCV-4	omplete A or MPSV-4	В	

 I understand that I will not be allowed to register for courses in any of the colleges of the DCCCD without the proper meningitis vaccination documentation as indicated above.

 I understand that 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 and seal, and contact information.

I certify that, to the best of my knowledge, the above information (including attachments) is true and correct. I also give my consent for the above immunization record to be entered into my student record.

Student's Signature – REQUIRED	Date
MINORS: Signature of Parent or Legal Guardian Required if student is under 18 Years of Age	Date
Printed Name of Parent or Legal Guardian	Relationship to Student