Bacterial Meningitis Vaccination Form

(For new and returning students aged 21 years or younger)

Student Name: _____ Del Mar ID: _____
Home Address: _____
Telephone Number: _____ Email: _____

Please read and place an "X" next to the statement that applies. Sign, date and submit to the DMC Office of Admission.

_____ I have received the Bacterial Meningitis Vaccine and attached an official vaccination record.

_____ My physician or health care professional has documented my meningococcal vaccine at the bottom of this form.

- I understand that proof of vaccination must include the physician's or health care professional's signature, date the vaccination was administered, stamp or seal and contact information
- I understand that I will not be allowed to register for classes at DMC without the meningococcal vaccine

Student Signature: _____ Date: _____

Vaccine Verification and Medical Facility Information (completed by healthcare professional)

Name of Administering Healthcare Facility:_____

Address: _____ Phone: _____

Name of Administering Physician/Healthcare professional:_____

Type of Vaccination: __MCV4 __MPSV4 __Other:_____

Date meningitis vaccine was administered: _____

I hereby verify/confirm that the above named student received the mandated Bacterial Meningitis vaccine as required and that the information provided on this form is true and accurate.

Signature of health care professional:

Place Official Stamp Here	_____	Place Official Seal Here
	Date _____	

For more information visit: www.delmar.edu/meningitis