healthyhorns

University Health Services

Bacterial Meningitis Medical Exemption
Allergy, Immunizations and Travel Clinic

The Texas Administrative Code, Part 1, Title 19, Chapter 21, Subchapter T, Rules §21.612, §21.613, and §21.614 define college students' requirements for meningococcal vaccination.

Rule §21.614 (b) A student, or parent or guardian of a student, is not required to submit evidence of receiving the vaccination against bacterial meningitis if the student, or parent or guardian of a student, submits to the institution:

(1) An affidavit or a certificate signed by a physician who is duly registered and licensed to practice medicine in the United States, in which it is stated that, in the physician's opinion, the vaccination required would be injurious to the health and well-being of the student.

Title 25, Part 1, Chapter 97, Subchapter B, Rule §97.62 Unless it is written in the statement that a lifelong condition exists, the exemption statement is valid for only one year from the date signed by the physician.

IMPORTANT: The document must be printed and completed by hand, photographhed, or scanned to be uploaded.

INSTRUCTIONS ON HOW TO UPLOAD FILE:

1. Log into your **MyUHS** patient portal with your UT EID and password.
2. Click on **Medical Clearances**. Then click on the **Update** button for Meningitis.
3. Enter the date your provider physician signed this document under **Administered Date.**
4. Navigate to **Immunization Upload** to submit this document.

IMPORTANT: Only one upload is allowed. After upload, your submission will be processed in the order it was received.

SECTION A: This section should be completed by the student:

Last Name: _____ First Name: _____

UT EID: _____ Date of Birth: ___/___/___ (Month / Day / Year)

Telephone: _____ Email Address: _____

SECTION B: This section should be completed by the health care provider:

☐ ***In my opinion, the required vaccination (bacterial meningitis) would be injurious to the health and well-being of this student.***

This exemption:

☐ Is permanent ☐ Expires on: ___/___/___ (Month / Day / Year)

Physician Signature: _____ Date: ___/___/___ (Month / Day / Year)

Physician Name (please print): _____ (Last Name / First Name)

Physician Address: _____ (Address / City / State / Zip Code)

Physician Phone Number: _____

(OPTIONAL) PHYSICIAN OR PRACTICE'S STAMP