

**BACTERIAL MENINGITIS IMMUNIZATION
MEDICAL EXEMPTION AFFIDAVIT**

As the physician of:

Student's Last Name

First Name

____ / ____ / ____
Date of Birth

UNTDallas Student ID #

This student has not been immunized against Bacterial Meningitis based on the conclusion at this time that it would be injurious to the student's health.

Comments:

Physician's Name

Physician's Signature

Physician's Address

____ / ____ / ____
Date