

Bacterial Meningitis Vaccination Record

Medical Exemption Affidavit

WCJC Student ID Last Name (Current Legal) First Name MI Date of Birth (MM/DD/YY) I attest that this student has not been immunized against Bacterial Meningitis based on the conclusion that, at this time, vaccination could be injurious to the student's health. Comments (Optional): Name of Healthcare Provider Provider's Phone Provider's Address City State/Zip Signature of Healthcare Provider Date Email completed form to registrar@wcjc.edu. Make a copy of your immunization documentation for your records. WCJC does not provide copies of immunization record submissions.	As the physician/healthcare provider for:				
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