MENINGOCOCCAL MENINGITIS VACCINATION
RESPONSE FORM

New York State Public Health Law 2167 requires that all college and university students enrolled for at least six (6) semester hours or the equivalent per semester, or at least four (4) semester hours per quarter, complete and return the following form to your college medical records office within thirty (30) days, or you will be blocked from registration and from attending classes.

PRINT STUDENT’S INFORMATION

First and Last Name ________________________ Date of Birth _____/____/____

College Name _____________________________ Social Security # ___________

Address __________________________________ Email ____________________

Phone Number (____) ______________

Check one box and sign below.

I have (for students under the age of 18: My child has):

☐ received the information regarding meningococcal meningitis disease and vaccine, including information regarding the availability and cost of the meningococcal meningitis vaccine. I have decided that I (my child) will not obtain immunization against meningococcal meningitis disease.

☐ received the information regarding meningococcal meningitis disease and vaccine, including information regarding the availability and cost of the meningococcal meningitis vaccine. I received the meningococcal meningitis immunization (Menomune TM) within the past 10 years. Date received: ___________

Signed ________________________________ Date ___________

(Student)

Signed ________________________________ Date ___________

(Parent/Guardian if student is a minor)