MENINGOCOCCAL MENINGITIS 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 complete and return the following form to your college campus health office, or you will be blocked from registration and from attending classes.

Print Student Information

Name: ___________________________ Social Security No.: ___________________________

Mailing Address: ___________________________ Date of Birth: __/__/________

City, State, Zip code ___________________________ month day year

Telephone: (__________) ___________________________ Email Address: ___________________________

Check one box and sign below.

☐ I have 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 (for students under the age of eighteen) will not obtain immunization against meningococcal meningitis disease at this time.

☐ I have received the information regarding meningococcal meningitis disease and vaccine, including information regarding the availability and cost of the meningococcal meningitis vaccine. I have/My child has (for students under the age of 18) received the meningococcal meningitis immunization (Menomune™) within the past 10 years.

Date immunization received: __/__/________

Signed: ___________________________ Date: ________________

(signature of student) month day year

For students under the age of 18:

Signed: ___________________________ Date: ________________

(signature of parent or guardian if student is a minor) month day year

Print name of parent/guardian: ___________________________