

Meningococcal Meningitis Vaccination Response Form

New York State Public Health Law requires that all college and university students enrolled for at least six semester hours complete and return this form. Please read the attached information regarding meningococcal meningitis disease and vaccination before completing this form.

Student Information

Last Name: First Name:

Date of Birth (MM/DD/YYYY): Student ID Number:

Email Address: Phone Number:

Vaccination Response (Please complete Option A OR Option B)

Option A: I have received the vaccine

I have received the meningococcal meningitis immunization (Menactra, Menveo, or Menomune) within the past 5 years.

Date of Immunization (MM/DD/YYYY):

Name of Healthcare Provider / Clinic:

Option B: I decline the vaccine

I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not being vaccinated. I have decided that I (or my child/ward) will NOT obtain the immunization against meningococcal meningitis disease.

To decline, type "I DECLINE" in the box:

Acknowledgment and Signature

By signing below, I certify that the information provided on this form is correct and that I have made an informed decision regarding the meningococcal meningitis vaccine.

Student Signature (or Parent/Guardian if under 18):

Date (MM/DD/YYYY):