MENINGITIS VACCINATION RESPONSE FORM

New York State Public Health Law requires all college students taking at least six credits per semester complete the following:

RETURN COMPLETED FORM TO ADDRESS AT TOP OF PAGE

STUDENT INFORMATION

Name ____________________________________________________________________________
                      Last                               First

Date of Birth ____________________         Student ID # ______________

Mailing address _________________________________________________________________

________________________________________________________________________________
                               Street

________________________________________________________________________________
                               City                                             State                                             Zip Code

Email ______________________________________       Phone ___________________________

CHECK ONE BOX AND SIGN BELOW after reading the Meningococcal Disease Fact Sheet.
To access this information, go to: www.newpaltz.edu/healthcenter/forms.html and click on the fact sheet.

☐ I have (for students under the age of 18: My child has) had the meningococcal meningitis immunization within the past 10 years
   Date received ____________________

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal meningitis disease.

Signed __________________________________________________    Date __________________

To be completed and signed by parent/guardian if student is a MINOR