

# MENINGITIS INFORMATION RESPONSE FORM

Student Health Services/State University of New York at New Paltz

New York State Public Health Law requires that **all college and university students enrolled for at least six (6) semester hours per semester or in the summer must complete and return the Meningitis Information Response Form below.** For more information, visit <http://www.newpaltz.edu/services/meningitis.pdf> or call the Health Center at (845) 257-3400.

## Colleges in NY State are required to maintain a record of the following for each student:

- A response to receipt of meningococcal disease and vaccine information (see Meningococcal Meningitis Fact Sheet below) signed by the student or student's parent or guardian, if the student is a minor. This material must include information on the availability and cost of meningococcal meningitis vaccine (Menomune™);
- AND EITHER**
- A record of meningococcal meningitis immunization within the past 10 years; **OR**
  - An acknowledgement of meningococcal disease risks and refusal of meningococcal meningitis immunization signed by the student or student's parent or guardian (for minor students only).

Please note that according to NYS Public Health Law, no institution shall permit any student to attend the institution in excess of 30 days without complying with this law. The 30 day period may be extended to 60 days if a student can show a good faith effort to comply.

---

## STUDENT INFORMATION

Name \_\_\_\_\_  
*Last* *First* *MI*

Summer Phone # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Email Address \_\_\_\_\_ Student ID# \_\_\_\_\_

Summer Mailing Address \_\_\_\_\_  
*Street* *City* *State* *Zip Code*

Social Security # 

--	--	--

--	--

--	--	--	--	--

Please **check one box and sign below**, after reading the Meningitis fact sheet on page 30:

- I \* (my child) had the meningococcal meningitis immunization (Menomune) within the past 10 years. (Please attach medical provider documentation)
- I 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

Return the completed form to: Peter B.T. Haughton, M.D.  
Student Health Center  
SUNY New Paltz  
75 S. Manheim Blvd. Suite 9  
New paltz, New York 12561-2443