



MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

Public Health Law 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 the Office of the National Registrar within thirty (30) days, or they will be blocked from registration and from attending classes.

Campus	Major	Term/Year	
Last Name	First	Middle	Maiden
Address			
City		State	Zip Code
Phone ()	Email Address		Date of Birth

CHECK ONE BOX AND SIGN BELOW:

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

- had the Meningococcal Meningitis immunization within the past 10 years.
 Date received _____ .
- received the information regarding Meningococcal 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 Meningoccal Meningitis disease.
- received the information regarding Meningococcal disease and vaccine, including information regarding the availability and cost of the Meningococcal Meningitis vaccine.
I will obtain immunization against Meningococcal Meningitis disease within thirty (30) days.

Student Signature	Date
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Parent/Guardian Signature (if student is a minor)	Date
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