MARIA COLLEGE

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

Upload this completed form to the electronic health record database as directed by your program

STUDENT INFORMATION		
Last Name:	First:	Middle:
Birth date: / /	Home Phone Number: ( )	Cell Phone Number: ( )
Street address:		
City:	State:	ZIP Code:
Email address:		

New York State 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.

CHECK ONE BOX AND SIGN BELOW	
☐	I have had the meningococcal meningitis immunization (Menonune) 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 will not obtain immunization against meningococcal meningitis disease.

REQUIRED SIGNATURE

_____ _____

Student Signature Date