MENINGOCOCCAL MENINGITIS VACCINE
RESPONSE FORM

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 to Dominican College Health Center at the above address.

* MENINGITIS VACCINE IS REQUIRED FOR ALL ATHLETES AND RESIDENT STUDENTS *
IT IS OPTIONAL FOR ALL OTHER STUDENTS AT THIS CURRENT TIME

Check one box and sign below.

I have:

☐ had the Meningococcal Meningitis Immunization. Date received: ____________________ *
   *Documentation by your healthcare provider required.

☐ 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.

Sign: ____________________________________________ Date: ______________________________
(Parent/Guardian if Student is under 18 years of age)

Print Student’s Name: ____________________________ Date of Birth: _________________

Student E-Mail Address: ___________________________ Student ID # __________________

Student Mailing Address: ____________________________

______________________________

Student Phone #: (__________)_________________________