MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

College of Staten Island
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New York State Public Health Law 2167 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 their college campus health office within thirty (30) days, or they will blocked from registration and from attending classes.

_____ _____/_____/_____
NAME (Please Print) LAST FIRST DATE OF BIRTH

_____
STUDENT MAILING ADDRESS APT # CITY STATE ZIP

_____
SOCIAL SECURITY # (OR STUDENT ID #) PHONE E-MAIL

Check one box and sign below:

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

☐ 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 meningococcal meningitis disease.

☐ received the information regarding meningococcal meningitis disease and vaccine, including information regarding the availability and cost of the meningococcal vaccine. I received the meningococcal meningitis immunization within the past ten (10) years.

Date received: _____

_____
SIGNED (STUDENT) DATE

_____
SIGNED (PARENT/GUARDIAN IF STUDENT IS A MINOR) DATE