

MENINGOCOCCAL MENINGITIS VACCINATION 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:

Manhattan College Health Services
Alumni Hall, Suite 104
4513 Manhattan College Parkway
Riverdale, N.Y. 10471

Check one box and sign below.

I have (for students under the age of 18: My son/daughter has):

- had the meningococcal meningitis immunization (Menomune tm) within the past 10 years.
Date received: _____

- 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 son/daughter) will **not** obtain immunization against meningococcal meningitis disease.

Signed _____ Date _____
(Parent/Guardian if student is a minor)

Print Student's name _____ Student _____ / _____ / _____
Date of Birth

Student
E-Mail address _____ Student ID# _____ - _____ - _____

Student
Mailing Address _____

Student Phone Number _____