



STUDENT HEALTH SERVICE
MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

RETURN FORM TO:

Student Health Service, 545 First Avenue, C122, NY, NY 10016 or fax to 212-263-3280

New York State Public Health Law 2167 requires that all university students enrolled complete and return this form.

Check one and sign below:

- I have had the meningococcal meningitis immunization, (Circle one: Menomune or Menactra) within the past 3 years. Date received: ___/___/___
I have read or have had explained to me the information regarding meningococcal meningitis disease. I will obtain immunization against meningococcal meningitis within 30 days from my private health care provider or the SoM Student Health Service.
I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. And I have decided that I will not obtain the immunization against meningococcal meningitis.

Signature: _____ Date: ___/___/___
Student Month Day Year

Print Student's Name:

First MI Last

Date of Birth: ___/___/___ Social Security #: ___-___-___

Student's Email Address:

Student's Mailing Address:

City: _____ State: _____ Zip: _____

Student's Phone Number: (_____) _____ - _____

Class of _____