

Employee/Student Health
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MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

New York State Public Health Law requires that all college and university students enrolled for a 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 SUNY Upstate Medical University Employee/Student Health.

Check one box and sign below.

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

_____ had the meningococcal meningitis immunization within the past 10 years.

Date received : _____

_____ read, or have had explained to me, the information regarding meningococcal meningitis disease.

I (my child) will obtain immunization against meningococcal meningitis **within 30 days** from my private health care provider or SUNY Upstate Medical University Employee/Student Health.

_____ 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.

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

Print Student's name: _____

Student Date of Birth: _____

Student ID#: _____

Student E-mail address: _____

Student Mailing Address: _____

Student Phone Number: (_____) _____

Colleges of: Medicine • Graduate Studies • Health Professions • Nursing • University Hospital

Improving the health of the communities we serve through education, biomedical research, and health care