

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 (print name) _____:

- Have had the meningococcal meningitis immunization within the past 10 years.
Date received: _____
- Have read, or have had explained to me, the information regarding meningococcal meningitis disease. I will obtain immunization against meningococcal meningitis prior to entering my program or **within 30 days** from SUNY Upstate Medical University Employee/Student Health. I further understand the cost of the vaccine will be incurred by me if obtained through Employee/Student Health.
- Have 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 will **not** obtain immunization against meningococcal meningitis disease.

Signed: _____ Date: _____

Date of Birth: _____ Upstate Student ID # _____

Student E-mail address: _____

Student Phone Number: (_____) _____