Meningococcal Meningitis Vaccination Response Form

New York State Public Health Law requires that all college and university students enrolled for at least six semester hours or the equivalent per semester, or at least four semester hours per quarter, complete and return the following form to SUNY Downstate Medical Center, Student-Employee Health Service. You will not be able to register unless the Student-Employee Health Service receives this form.

Check one statement and sign below.

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

_____ had meningococcal meningitis immunization within the past 10 years.

Date received: ________________________

(NOTE: If you (your child) received the meningococcal vaccine available before February 2005, called Menomune ™, please note this vaccine’s protection lasts for approximately 3 to 5 years. Revaccination with the new conjugate vaccine, called Menactra ™, should be considered within 3-5 years after receiving Menomune ™.)

_____ 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 ___________________________________________________

Date of Birth ______________  Phone Number ______________________________

Student Mailing Address ________________________________________________

Student e-mail Address _________________________________________________

Questions or comments: immunize@health.state.ny.us  Revised March 2009