Meningococcal Meningitis Vaccination Response Form

You must return this form!

THIS FORM MUST BE SUBMITTED PRIOR TO START OF CLASS.

REQUIRED OF ALL STUDENTS.

I am a (check one) ☐ commuter ☐ resident student

Please print all information

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 complete and return this form to Hilbert College.

Student Name: ___________________________________________ Date of Birth:_____ / _____ / _____

Check one and sign below.

Resident students must receive a meningitis immunization.

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

☐ 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 understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal meningitis disease.

STUDENTS MUST SIGN BELOW:

Signature: ___________________________________________ Date: _____ / _____ / _____

(Practice/Guardian if student is a minor)

Print Student’s Name: ___________________________________________

*If you have a medical condition that should be reported to the College’s Wellness Center please indicate your consent to the Nurse Practitioner contacting you.

Student Signature: ___________________________________________

FOR OFFICE USE ONLY

Student ID# ___________________________________________

FOR MORE INFORMATION

Health Records: (716) 649-7900, ext. 230