Meningococcal Meningitis Vaccination Response Form Refer to page 24.

You must return this form!

STUDENTS WHO FAIL TO RETURN THIS FORM BY OCTOBER 1 (FALL ENROLLEES) OR FEBRUARY 1 (SPRING ENROLLEES) WILL NO LONGER BE ALLOWED TO ATTEND CLASSES AT HILBERT COLLEGE.

REQUIRED OF ALL STUDENTS.

Please print all information 2010-11

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:_____ /_____ /_____

(Parent/Guardian if student is a minor)

Print Student's Name: ________________________________

FOR OFFICE USE ONLY

Student ID# ________________________________

For more information

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