

Meningococcal Meningitis Vaccination Response Form

FOR RETURNING STUDENTS ONLY. (New students do not use this form.)

RETURN FORM TO:

NYU Student Health Center • Immunization Record Services • 726 Broadway, 3rd Floor, Suite 357 • New York, NY 10003
 Tel: (212) 443-1199

New York State Public Health Law 2167 requires that all college and university students enrolled for at least (6) semester hours or the equivalent per semester, or at least four (4) semester hours per quarter, complete and return this form.

Check one box and sign below

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

had the meningococcal meningitis immunization (Menomune™) within the past 10 years.

Date received: _____ / _____ / _____
Month Day Year

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 NYU Student Health Center, Allergy and Immunology Services.

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.

Signature: _____	Date: _____ / _____ / _____ <small>Month Day Year</small>
<small>Student / Parent or Guardian</small>	
Print Student's Name: _____ <small>First M.I. Last</small>	
Date of Birth: _____ / _____ / _____	University I.D. Number: _____ <small>(9-digit Student I.D. Number)</small>
Student's Email Address: _____	
Student's Mailing Address: _____	
City: _____ State: _____ Zip: _____	
Student's Phone Number: (_____) _____ - _____ (_____) _____ - _____ <small>Local Permanent</small>	