MENINGOCOCCAL MENINGITIS VACCINATION
RESPONSE FORM

New York State Public Health Law requires that all college and university students enrolled for at least six (6) semester hours per semester complete and return the following form to the Utica College Student Health Center.

Check one box and sign below:
I have (for students under the age of 18: My child has:)

☐ had the meningococcal meningitis immunization within the last 10 years.

Menactra™ Date received_____

Menomune™ 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.

Student signature _____ Date _____
(Parent or Guardian if student is a minor)

Please print

Student's name _____ Date of birth _____

Student email _____

Student mailing address _____

_____

Student phone number (_____) _____

Utica College
Student Health Center
204 Strebel Student Center
1600 Burrstone Road
Utica, NY 13502-4892
(315) 792-3094
FAX (315) 792-3700