DOWNSTATE
HEALTH SCIENCES UNIVERSITY

University Hospital of Brooklyn
College of Medicine
School of Graduate Studies
College of Nursing
School of Health Professions
School of Public Health

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 Health Sciences University, Student-Employee Health Service. You will not be able to register unless the Student Health Center receives this form.

Check one of the following statements and sign below.

☐ I have had meningococcal meningitis immunization within the past **5** years.

Date vaccine received: _____

☐ I have read the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I will **NOT** obtain immunization against meningococcal meningitis disease.

By typing my name below, I acknowledge that I read and understand what is outlined in this form. I also agree that this form of electronic signature has the same effect as a manual signature.

Date of Birth _____ Cell Phone Number _____

Student's Mailing Address _____

Student's e-mail Address _____

Printed Name _____ Date _____

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