KINGSBOROUGH
COMMUNITY COLLEGE
★ DREAMS BEGIN HERE ★

PLEASE SIGN AND RETURN TO THE MY TURN OFFICE, F219.
DOCTOR VISIT IS NOT REQUIRED.

THE CITY UNIVERSITY OF NEW YORK

MENINGOCOCCAL MENINGITIS VACCINATION
RESPONSE FORM

New York State Public Health Law 2167 requires that all college and university students enrolled for at least six (6) semester hours or the equivalent per semester, or at least four (4) semester hours per quart, complete and return the following form to your college campus health office within thirty days, or you will be blocked from registration and from attending classes.

PRINT STUDENT'S INFORMATION

First & Last Name_____ Date of Birth_____/___/_____

College Name _____ Empl. #_____

Student Mailing Address _____ Email_____

_____

Phone Number (_____) _____

Check one box and sign below:

I have (not students under the age of 18: My child has):

( ) received the information regarding meningococcal meningitis disease and vaccine, Including information regarding the availability and cost of the meningococcal meningitis vaccine. I have decided that I (my child) will **not** obtain immunization against Meningococcal meningitis disease.

( ) received the information regarding meningococcal meningitis disease and vaccine, Including information regarding the availability and cost of the meningococcal meningitis vaccine. I received the meningococcal meningitis immunization (Menomune) within the past 10 years. Date received: _____

Signed _____ Date_____
(Student)

Signed _____ Date_____
(Parent / Guardian if student is a minor)

Updated 1/2016