NEW YORK MEDICAL COLLEGE
School of Health Sciences and Practice
—and—
INSTITUTE OF PUBLIC HEALTH

Meningococcal Meningitis Vaccination Response Form

New York State Public Health Law 2167 requires that all college and university students complete and return the form below. If you are taking classes on campus, please return this form with your acceptance agreement. If we do not receive this form by the start of classes, you will be blocked from attending classes and from subsequent registrations.

PRINT STUDENT'S INFORMATION:

First and Last Name _____Date of Birth __/__/__

College Name_____SSN _____

Address _____ Email _____

_____

Home phone number (____)_____ Cell number (_____)_____

Check one box and sign below:

I have:

- ☐ I have decided that I will <u>not</u> obtain immunization against meningococcal meningitis disease.
- ☐ I have received the meningococcal meningitis immunization (Menomune TM) within the past 10 years.

  Date Received: _____

Signed _____ Date_____
(student)

H:\Immunizations