

C.W. POST CAMPUS OF LONG ISLAND UNIVERSITY

MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

New York State Public Health Law requires that all students complete and return this form in the envelope provided to Student Health and Counseling Center, C.W. Post Campus, Long Island University, 720 Northern Blvd., Brookville, New York 11548. Also in this envelope, please enclose the Report of Medical History and the Report of Health Evaluation.

Check one box and sign below.

- I had the meningococcal meningitis immunization (Menomune/Menactra TM) within the past 10 years. Date received: _____
- I read or have had explained to me the information regarding meningococcal meningitis disease. I will obtain immunization against meningococcal meningitis within 30 days from my private health care provider.
- I have 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 will not obtain immunization against meningococcal meningitis disease.

Student Signature
(Parent/Guardian if student is a minor)

Date

Print Student Name

Date of Birth

Student Soc. Sec. No./Student ID No.

Phone Number

Street Address

City, State, ZIP Code