

**THE COLLEGE AT BROCKPORT  
STATE UNIVERSITY OF NEW YORK  
HAZEN HEALTH CENTER  
350 NEW CAMPUS DRIVE  
BROCKPORT, NEW YORK 14420  
PHONE: (585) 395-2414  
FAX: (585) 395-2559**

***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 complete and return the following form to SUNY College at Brockport Health Center.

***This form must be completed.*** Students may not attend classes after the first 30 days of school, without either the immunization or declination of immunization.

**Check one box and sign below.**

I have (for students under the age of 18: My child has):

- had the meningococcal meningitis immunization (Menomune™ or Menactra™) within the past (ten) 10 years.  
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. I understand that this decision can be changed at any time, and that the vaccine can be obtained at the Student Health Center and Monroe County Health Department. It also may be available at my health care provider or local health department.

Student's signature \_\_\_\_\_ Date \_\_\_\_\_  
(Parent / Guardian if student is a minor)

Print student's name \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Student e-mail address \_\_\_\_\_ Student ID# \_\_\_\_\_

Student mailing address \_\_\_\_\_  
\_\_\_\_\_

Student phone number ( ) \_\_\_\_\_