



**NEW YORK CITY  
COLLEGE OF TECHNOLOGY**

THE CITY UNIVERSITY OF NEW YORK

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**Meningococcal Vaccination Response Form**

**Immunization records are required prior to registration. Please complete this form and return it to Room NG17.**

*Document **must** be legible. If any portion of this document is illegible it will not be processed.  
Students are responsible for obtaining an official translation of foreign records prior to submission.*

Part 1: Student Information (Please Print)			Date of Birth	Age
Name: _____ <i>Last Name First Name Middle Initial</i>			____/____/____	____
Social Security #	Empl ID #	Daytime Telephone #	E-mail Address	
____-____-____	_____	( ) _____-____	_____	

Part 2: Meningococcal Meningitis	To be completed by the student or parent/guardian.
<b>Instructions:</b>	
(1) Please read the attached Meningococcal Disease Fact Sheet. (2) Check only <u>one</u> box in Section A. (3) Sign and date Section B. <b>If you are under 18 years old, Part B <u>must</u> be signed by your parent/guardian.</b>	
I have (for students under the age of 18: My child has):	
A.	<input type="checkbox"/> had the meningococcal immunization within the past 5 years. <b>(You <u>must</u> attach the vaccine record.)</b> <i>Note: The Advisory Committee on Immunization Practices recommends that all first-year college students up to age 21 years should have at least 1 dose of Meningococcal ACWY vaccine not more than 5 years before enrollment, preferably on or after their 16th birthday, and that young adults aged 16 through 23 years may choose to receive the Meningococcal B vaccine series. College and university students should discuss the Meningococcal B vaccine with a healthcare provider.</i>
	<input type="checkbox"/> read, or have had explained to me, the information regarding meningococcal disease. I (my child) will obtain immunization against meningococcal disease <b>within 30 days</b> from my private health care provider.
	<input type="checkbox"/> read, or have had explained to me, the information regarding meningococcal disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) <b>will not</b> obtain immunization against meningococcal disease.
B.	_____ <b>Signature (Parent/Guardian if student is under 18 years old.)</b>
	_____ / _____ / _____ <b>MM DD YYYY</b>

**Additional information about meningococcal disease and vaccination is available on the following websites:**

- [www.health.state.ny.us](http://www.health.state.ny.us) (New York State Department of Health)
- <http://www.cdc.gov/vaccines/vpd-vac/> (Centers for Disease Control and Prevention)
- [www.acha.org](http://www.acha.org) (American College Health Association)

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Staff Initials: _____	Date Received: _____/_____/_____	Date Entered: _____/_____/_____