When Completed, Mail Directly to:
Director, Student Health Service
Stony Brook University
Stony Brook, New York 11794-3191

Stony Brook University

STUDENT HEALTH SERVICE
Tel: (631) 632-6740
TDD: (631) 632-6171
Fax: (631) 632-6936

Meningitis Response Form

STUDENT LAST NAME (PLEASE PRINT)	FIRST NAME	MIDDLE NAME	STONY BROOK ID#	
HOME ADDRESS	STREET/APT.#	CITY/TOWN	STATE/PROVINCE	ZIP CODE COUNTRY (IF NOT U.S.)
HOME PHONE	CELL PHONE		E-MAIL	
EMERGENCY CONTACT	RELATIONSHIP		PHONE	

New York State Public Health Law and Stony Brook University Policy require that all students must verify by their signature that they have received information about meningococcal disease and have made an informed decision about whether or not to receive immunization against meningococcal disease. Student must demonstrate compliance with this requirement within 30 days after the first day of classes. The Registrar will block and de-register students who fail to comply with this health requirement.

Student may comply with this law by reading the required information regarding meningitis at this Web site: ***http://studentaffairs.stonybrook.edu/shs/docs/Meningitis.pdf*** and then completing this form.

If you are 18 years of age or older or you do not wish to use this form, this requirement can be met by logging on to your SOLAR account and reading the information and submitting your response electronically.

Your response to this form must be received two weeks before your Orientation date. It is important that we receive the immunization information before that date so your form can be processed early to avoid registration/de-registration problems.

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 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.

SIGNATURE (PARENT/GUARDIAN IF STUDENT IS A MINOR)	RELATIONSHIP	DATE

PLEASE REMEMBER TO MAKE A COPY OF THIS FORM FOR YOUR RECORDS BEFORE YOU SEND IT IN.