College Health Service

Tel: (518) 629-7468 fax; (518) 629-7471

Meningitis self reporting form/Consent for students under 18 years of age

H00# _____ Birth Date _____/_____/_____ Sex ☐ Male ☐ Female

Student Last Name (please print) First Name Middle Name

Home Address Street/Apt. # City/Town State/Province Zip Code Country (if not U.S.)

Cell Phone Home Phone E-Mail

For Student Under 18 years of Age only

To Avoid delay in treatment when medical problems arise, we request that the following statement be signed by a parent or legal guardian: I hereby grant permission to the healthcare providers and nurses of the Hudson Valley Community College Health Service to evaluate and treat my son/daughter/ward in care of illness/injury. I also hereby grant permission to immunize my son/daughter/ward in cases where immunization is necessary as part of a treatment plan or when needed for prevention of illness.

_____ _____

Parent/Guardian Signature Relationship Date

New York State Public Health Law and Hudson Valley Community College Policy require that all students enrolled for at least six(6) semester hours or the equivalent per semester, complete and return the following form to Hudson Valley community College.

Student may comply with this law by reading the required information regarding meningitis at this website: http://www.health.ny.gov/publications/2168.pdf and then completing this form.

Check one box and sign below. I have (For students under the age of 18: My child has):

☐ had the Meningococcal immunization within the past 5 years. The vaccine record will be submitted to the Student Health Service.[Note: The advisory Committee of 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 aged16 through 23 years may choose to receive the Meningococcal B vaccine series. College and university should discuss the Meningococcal B vaccine with a health care provider.]

☐ read or explained to me, the information regarding meningococcal disease. I (my child) will obtain immunization against meningococcal disease within 30 days from my private health care provider.

☐ 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 or guardian if student is under the age of 18). Relationship Date

When Completed, Mail Directly to:

College Health Service / Hudson Valley Community College / 80 Vandenburgh Avenue / Troy, NY 12180 CHS003-16