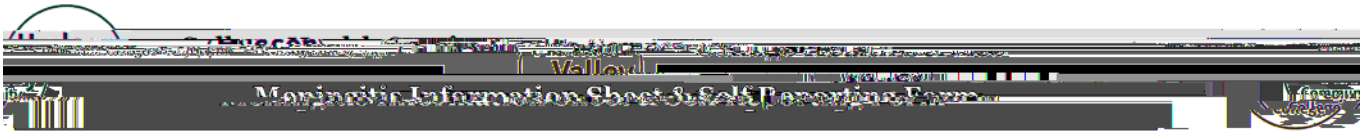
Please check one box and sign below:

- ☐ I have received the Meningococcal immunization within the past 5 years.
  (You must submit proof of the vaccine record to the Health Service Office).
- ☐ I will obtain immunization against meningococcal disease within 30 days from my private health care provider and submit that record to the Health Service Office.
- ☐ I understand the risks of not receiving the vaccine. I am declining immunization against the meningococcal vaccine. Date____/_____/_____

Please see reverse side for consent for services for those students who are under



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

When Completed, Mail or Fax Directly to:

College Health Service Hudson Valley Community College 80 Vandenburgh Avenue Troy, NY 12180 518-629-7471