SULLIVAN
COUNTY COMMUNITY COLLEGE
S - U - N - Y

MENINGITIS INFORMATION RESPONSE FORM

New York State Public Health Law requires that all college and university students enrolled for at least six (6) semester hours or the equivalent per semester, or at least four (4) semester hours per quarter, complete and return the following form to:

Sullivan County Community College
112 College Road
Loch Sheldrake NY 12759-5151
Attn: Health Services

This vaccine is not required to attend Sullivan County Community College, however, this form IS required by New York State Public Health Law, to be signed and kept on file in the Student Health Services Office.

Check ONE box and sign below.

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

- ☐ had the meningococcal meningitis immunization (Menomune™) within the past 10 years.
  Date received: _____ **Please attach proof from your 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.

Signed by Student _____ Date _____

Signed _____ Date _____
(Parent / Guardian if student is a minor)

Student's name _____ Student Date of Birth / /

Student E-mail address _____ Student ID# _____ (if available)

Student Mailing Address _____

_____

Student Phone number ( ) _____

SULLIVAN COUNTY COMMUNITY COLLEGE
Parental Permission to Treat

ear Parents and Guardians of Applicants under Eighteen:

order to provide any emergency care that may be necessary for students, it is requested that you sign and have notarized e consent for emergency treatment below.

e assured that we make every effort to notify parents/guardians at once in case of serious accidents or illnesses when ese come to our attention. Your cooperation in this matter is appreciated.

_____ pursuant to the authority vested in me as _____ of
PARENT/GUARDIAN NAME (PLEASE PRINT) PARENT / GUARDIAN

_____ do hereby authorize the Medical Staff of Sullivan County Community College,
STUDENT'S FULL NAME

on consultation with a practicing physician or surgeon to exercise for me and on my behalf, all rights and duties with ference to consenting to appropriate medical, physical and surgical treatment, anesthetics, medicine and hospitalization, cluding care and treatment, by any hospital staff surgeon, physician or radiologist which they may deem necessary for e emergency care of my child.

_____
PARENT / GUARDIAN SIGNATURE

Signed _____
NOTARY PUBLIC SIGNATURE

Subscribed before me this _____ day of _____ 20____

Notary Public (with Seal) _____

HEALTH REPORT

Please print or type all information. Thank you.

me: _____
LAST FIRST MI

dress: _____
STREET CITY STATE ZIP

ent / Guardian: _____ Phone # _____
LAST FIRST (area code)

dress _____
STREET CITY STATE ZIP

mary Physician: _____ Phone # _____
(area code)

dress _____
STREET CITY STATE ZIP

ergies: _____

dical History (List all diseases: Diabetes, Heart Disease, Seizures, Mental Illness, Other): _____

_____

son to notify in case of emergency: Name: _____

dress _____
STREET CITY STATE ZIP

one (home): _____ Phone (work): _____
(area code) (area code)