AGE:

THE CITY UNIVERSITY OF NEW YORK
IMMUNIZATION CONSENT FORM FOR MENINGITIS VACCINATIONS

COLLEGE	TELEPHONE	EMERGENCY CONTACT#		
LAST NAME		FIRST		M.I.
□ MALE □ MTF □ FEMALE □ FTM	MOTHER'S MAIDEN NAME	DATE OF BIRTH Month Day Year		
ADDRESS	APT.	CITY	STATE	ZIP

SCREEN A

ALL INFORMATION PROVIDED WILL BE KEPT CONFIDENTIAL.

PLEASE CHECK THE APPROPRIATE BOX (ES) BELOW

1. Do you have health insurance? □ **YES** □ **NO** □ **DON'T KNOW**
2. If yes, who is your insurance carrier?

		Covered by:
□ CUNY Endorsed GHI Plan	□ Sponsored by Parent/Guardian	□ Spouse
□ Family Health Plus	□ Child Health Plus	□ Domestic Partner
□ NYS Healthy NY	□ Private (Aetna, BlueCross, HIP)	□ Employee
□ Other: (specify)_____________	□ Medicaid	

SCREEN B

	CIRCLE ONE		
1. Are you feeling sick with anything other than a cold today?	**YES**	**NO**	**DON'T KNOW**
2. Have you ever been vaccinated against invasive meningococcal disease?	**YES**	**NO**	**DON'T KNOW**
a. If yes, when, where (US or other) and with what type?_______________________________________			
3. Have you ever had an allergic or neurological reaction to any vaccine?	**YES**	**NO**	**DON'T KNOW**
4. Have you ever had a severe allergic reaction to anything requiring (e.g., hives, breathing difficulties, shock) emergency treatment?	**YES**	**NO**	**DON'T KNOW**
5. Do you have any allergies to medications or foods?	**YES**	**NO**	**DON'T KNOW**
a. If so, what type of allergic reaction?_________________________________			

Interviewed by: ____

CONSENT

I have read the information contained in the Vaccine Information Statement about the disease(s) and the vaccine(s). I have had a chance to ask questions which, if any, were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated below be given to me or to the person named for whom I am authorized as parent, guardian, or long term custodian to make this request.

Yo he leido la Declaracion de Vacunas acerca de la(s) enfermedad(es) y la(s) vacuna(s). He tenido la oportunidad de hacer preguntas las cuales, si hubo algunas, fueron contestadas a mi satisfaccion. Creo que comprendo los beneficios y riesgos de la(s) vacuna(s) y pido que me den la(s) vacuna(s) indicada(s) mas abajo a mi o a la persona nombrada por quien estoy autorizado(a) como padre, guardian, o cuidador por largo tiemp[o para hacer esta peticion.

PATIENT/PARENT SIGNATURE **DATE**

FIRMA DEL PACIENTE/PADRE ________________________________ **FECHA** ______________________

OFFICE USE ONLY

Vaccine	Dose #	Dosage	V.I.S.	Injection Site	Manufacturer I.D.	Lot #	Expiration Date
MENINGITIS				LUA/RUA			

Innoculator Signature: **Date:**