COLBY COMMUNITY COLLEGE
WAIVER FOR THE MENINGOCOCCAL VACCINATION

I have received and reviewed the information provided on the risks of meningococcal disease and the risks and benefits of meningococcal vaccine. After reviewing the materials on the dangers of meningococcal disease, I choose to waive receipt of meningococcal vaccine.

Printed Name: _____ **Date of Birth:** ____/____/____

Student ID or Social Security Number: _____

_____ _____
Student Signature **Date**

_____ _____
Parent/Legal Guardian Signature (if student is under 18 years of age) **Date**

OR
VERIFICATION OF VACCINATION

Printed Name: _____ **Date of Birth:** ____/____/____

Student ID or Social Security Number: _____

_____ _____
Student Signature **Date**

_____ _____
Parent/Legal Guardian Signature (if student is under 18 years of age) **Date**

I have received the meningococcal vaccine on _____ **(date).**

_____ _____
Name of Provider (or attached copy of meningococcal vaccine verification) **Provider Phone Number**

_____ _____
Address of Provider **City** **State** **Zip**

_____ _____
Signature of Provider (or attached copy of meningococcal vaccine verification) **Date**

Please send or fax waiver and/or verification form along with completed housing contract to:

Colby Community College
Attention: Student Health
1255 South Range
Colby, KS 67701
Fax: (785) 460-4691