

COLBY COMMUNITY COLLEGE
WAIVER FOR THE MENINGOCOCCAL VACCINATION

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

Printed Name: _____
Birthdate: ___/___/___ 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: _____
Birthdate: ___/___/___ 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 Code _____

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

Please send or fax waiver and/or verification form to:

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

Colby Community College does not discriminate on the basis of race, color, gender, age, disability, national origin or ancestry, sexual orientation or religion. For inquiries, contact the Vice President of Students Affairs, Title IX and ADA Coordinator, Colby Community College, 1255 S. Range Ave., Colby, KS 67701 785.460.5490.

