

Howard University Student Health Center
2139 Georgia Avenue, N.W.
Washington, D.C. 20059
Phone (202) 806-7540 ~ Fax (202) 806-7416

Request to Waive the Meningococcal Vaccine Requirement

Last Name

First Name

Date of Birth

Age

Student ID#

Please read and initial before each statement. Your initials indicate you understand and agree with the statement.

1. ____ I have received and reviewed the information provided by Howard University on the risk of contracting meningococcal disease and the availability and effectiveness of the vaccine.
2. ____ I am declining the meningococcal vaccine on my own behalf since I am eighteen (18) years of age or older.

OR

____ As the parent or legal guardian of the student who is less than eighteen (18) years of age, I am declining the meningococcal vaccine on the behalf of the student.

3. ____ I understand that if I reconsider my decision, I may return to the Student Health Center to receive the vaccine.

I hereby release the Student Health Center and its staff from all responsibility for any consequences of my decision. I also understand that the Student Health Center will make any necessary referrals (as indicated) in the event of an emergency.

Student's Signature

Date

Responsible Parent/Guardian

Relationship to Student

Date

Waiver reviewed and granted by: _____
Howard University Student Health Center Provider Date