



WAIVER OF VACCINATION AND RELEASE OF RESPONSIBILITY

MENINGOCOCCAL VACCINE WAIVER

BE IT KNOWN that on this date I, _____,
(Name of Student)

Date of birth: _____

have been fully informed by reading the Centers for Disease Control and Prevention's *Meningococcal Vaccines – What You Need to Know* Vaccine Information Statement and understand that my health could be negatively affected and my life possibly endangered by not receiving the Meningococcal Vaccine. The reason for my completing this waiver is (check one):

_____ Personal

_____ Medical

_____ Religious

_____ Unavailability of the Vaccine

I declare myself to be a person of the full age of majority and to be mentally competent. I hereby assume full responsibility for any and all possible present and future results or complications of my condition as a result of not receiving the vaccination.

I do further hereby now and forever free and release Our Lady of Holy Cross College and the Department of Health and Hospitals and all its agents, attending health care professionals, and other personnel from any and all legal or financial responsibility as a result of not receiving the vaccination.

I certify that I have read (or have had read to me) and that I fully understand this Waiver of Vaccination and Release from Responsibility. All explanations were made to me and all blanks completed before signing my name. I have elected to not receive the vaccination of my own free will.

Signature of Student

Signature of Parent or Guardian

Date