



PROVIDENCE
COLLEGE

**Meningococcal Vaccination Waiver and Consent Form
Fall, 2015**

Name: _____ Student ID: _____ Class Year: _____
Last First MI

Email: _____ Phone: _____ Date of Birth: _____
mm/dd/yyyy

The information below includes the risk factors and dangers of the diseases as well as the information on the availability and effectiveness of the respective vaccines for persons who are at risk for the diseases. Sources: The Rhode Island Department of Health (HEALTH) and the Centers for Disease Control and Prevention (CDC).

What causes meningococcal disease and how does the disease spread?

Meningococcal meningitis is an infection of the lining that surrounds the brain and spinal cord. The bacterial infection is spread through direct secretions from the nose or mouth through activities such as kissing; or sharing food, drinks, water bottles, toothbrushes, eating utensils, or cigarettes. Meningococcal disease can be treated with antibiotics, but quick medical attention is extremely important.

What are the symptoms?

Meningitis may present as sudden onset of fever, headache, and stiff neck. It will often have other symptoms, such as nausea, vomiting, increased sensitivity to light and altered mental status and/or a skin rash. The symptoms of bacterial meningitis can appear quickly or over several days. Typically they develop within 3-7 days of exposure.

Is there a vaccination?

Yes, there are several; however, the Rhode Island Department of Health (HEALTH) and the Centers for Disease Control and Prevention (CDC) Health officials notified the College that the meningitis vaccination, which most students received prior to coming to campus, is not effective in protecting against the Serogroup B strain of meningitis.

Acknowledgement and Assumption of Risk (please initial)

_____ I acknowledge and fully understand that there may be risks associated with my decision to receive the vaccine or not to receive the vaccine; I understand that Providence College assumes no responsibility for my decision and I agree to release and hold harmless Providence College, its trustees, employees, and agents, regarding any and all claims associated with my decision, which reflects my free and voluntary choice.

Election to Receive the Meningococcal Meningitis, Serogroup B Vaccination

_____ **I hereby certify that I have read the above information and I have elected to receive the vaccine for Meningococcal Meningitis, Serogroup B.**

_____ **I hereby certify that I have read the above information and I have elected NOT to receive the vaccine for Meningococcal Meningitis, Serogroup B.**

Signature of Student (or Parent/Guardian if student is under 18): _____

Date: _____

For more information about Meningococcal Meningitis, go to www.cdc.gov or www.health.ri.gov