



**ROCKHURST UNIVERSITY
MENINGITIS VACCINE REQUIREMENT**

In accordance with Missouri State Law
FILL OUT SECTION 1 OR 2

Return this form to:
Rockhurst University
Office of Student Development
Kansas City, MO 64110
Fax: 816-501-4845

STUDENT NAME: _____ Student ID # _____

SECTION 1

To be completed by a health care provider: (Attached documentation of vaccination from a physician or health clinic is also acceptable.)

The above-named individual has received the meningitis vaccine as required by Rockhurst University and the State of Missouri for residential students.

Date of Meningitis vaccine administration: _____ * Vaccine Type _____

Health care provider name: _____ Date: _____

Health care provider signature: _____ Phone _____

*The vaccine is effective for approximately 3-5 years. Students whose vaccine was not administered within the last 5 years will be asked to update their immunization in order to comply with University policy.

SECTION 2

VACCINE WAIVER

To be completed by an individual (or parent/guardian for individual less than 18 years of age) requesting an exemption from the meningitis vaccine requirement:

For individuals 18 years of age and older:

I am 18 years of age or older. I have received and read the information in the Meningitis Disease Fact Sheet provided by Rockhurst University explaining the risks of meningitis disease, and the effectiveness and availability of the meningitis vaccine at Rockhurst University. I acknowledge that meningitis disease is a rare, but life-threatening illness. I understand that under Rockhurst's policy, all students living on Rockhurst campus are required to be vaccinated against meningitis disease. With this waiver, I seek exemption from this requirement. I voluntarily agree to release, discharge, indemnify and hold harmless Rockhurst University, its officers, employees and agents from any and all costs, liabilities, expenses, claims, demands, or causes of action on account of any loss or personal injury that might result from my decision not to be immunized against meningitis.

Name of student: _____ Date: _____

Signature of student: _____

For individuals under the age of 18:

I am the parent or guardian of _____ who will be a student at
(Name of individual enrolled at Rockhurst University)

Rockhurst University. I have received and read the information in the Meningitis Disease Fact Sheet from the University about meningitis disease and the effectiveness and availability of the vaccine at the Rockhurst University. I acknowledge that the disease is rare but life threatening. I understand that Rockhurst (in accordance with Missouri Law) requires that an individual living on Rockhurst campus shall receive vaccination against meningitis disease unless a waiver is signed. I choose to waive receipt of meningitis vaccine for the above-named individual. I voluntarily agree to release, discharge, indemnify and hold harmless Rockhurst University, its officers, employees and agents from any and all costs, liabilities, expenses, claims, demands, or causes of action on account of any loss or personal injury that might result from my decision not to have the above-named individual immunized against meningitis.

Name of parent/guardian: _____ Date: _____

Signature of parent/guardian: _____