



**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  
**DUE BY: August 14, 2009**

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. I understand the meningitis vaccine is now recommended for all young people. 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)

I have received and read the information in the Meningitis Disease Fact Sheet from the University about meningitis disease. I understand the meningitis vaccine is now recommended for all young people. 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: \_\_\_\_\_