INFORMED CONSENT TO ADMINISTER
MenQuadfi®-A/C/Y/W

FOR STUDENTS UNDER 18 YEARS OF AGE

**Please note that this form is necessary only if your student is under 18 years of age.*

I, the undersigned, authorize the nursing staff at West Liberty University Health Service, to administer the meningitis vaccine (MenQuadfi®-A/C/Y/W-135) to my son or daughter in an effort to provide immunization against meningococcal disease.

I understand that MeQuadfi® is safe and can provide protection against four out of the five strains of the disease (Serogroups A, C, Y, and W) These four strains cause nearly 70% of meningococcal meningitis on college campuses.

Most common side effects in clinical trials of these vaccines included soreness, redness or swelling at the vaccination site. These symptoms were mild, did not require treatment and did not last more than 48 hours.

I have read the literature provided which outlines the benefits of the meningitis vaccine as well as the possible side effects.

Student's Name: **PLEASE PRINT**

Last: _____ First_____

Date of Birth _____ SS#: _____

Signature of Parent/Guardian: _____ Date: _____

____ I would like my son/daughter to receive MenQuadfi®-A/C/Y/W-135 (Meningococcal {Groups A, C, Y, and W-135} Polysaccharide Diphtheria Toxoid Conjugate Vaccine)

Signature of Parent/Guardian _____ Date: _____

This completed form must be returned with the pre-payment form, if your son or daughter is under 18 years of age.