CLEVELAND STATE UNIVERSITY

HEALTH INSURANCE & IMMUNIZATION FORM

Name:_____ Date of Birth: ___ /____ /____

CSU ID:_____

Current Address:
_____
_____

Permanent Address:
_____
_____

Phone Number: _____

Email: _____

Meningococcal and Hepatitis B Vaccination Status

I, the undersigned student (if 18 years of age or older) or parent (if student is under 18), have read and understand the information provided to me about Meningococcal Meningitis and Hepatitis B. I understand the benefits and risks of being vaccinated against these diseases. I am aware that the vaccines for Meningococcal and Hepatitis B are available at the CSU Health and Wellness Services, and the entire cost can be billed to most insurance should I decide to receive them.

The information below regarding my/my child's vaccination status is accurate and is being provided in compliance with the Ohio Revised Code Section 3701.133 (B).

Meningococcal A, C, W, Y vaccine received: ☐ Yes ☐ No
If yes, please list the dates: 1st Dose ____ /____ /____
2nd Dose ____ /____ /____

Meningococcal B vaccine received: ☐ Yes ☐ No
If yes, please list the dates: 1st Dose ____ /____ /____
2nd Dose ____ /____ /____
3rd Dose ____ /____ /____

Hepatitis B vaccine received: ☐ Yes ☐ No
If yes, please list the dates: 1st Dose ____ /____ /____
2nd Dose ____ /____ /____
3rd Dose ____ /____ /____

Signature_____ Date ____ /____ /____
If student is under 18 years of age please have parent sign.

REV. 04/2016

A copy of this form will kept by the Department of Residence Life and the original sent to Health and Wellness Services.