

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 vaccine (MCV4) received at age 16 or older: Yes No
Date of first dose: ___ / ___ / ___ Date of second 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.