

CLEVELAND STATE UNIVERSITY

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 received:  Yes  No  
If yes, please list the date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Hepatitis B vaccine received:  Yes  No  
If yes, please list the dates:  
1<sup>st</sup> Dose \_\_\_\_/\_\_\_\_/\_\_\_\_  
2<sup>nd</sup> Dose \_\_\_\_/\_\_\_\_/\_\_\_\_  
3<sup>rd</sup> Dose \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

If student is under 18 years of age please have parent sign.