



OHIO DEPARTMENT OF HEALTH

Meningococcal and Hepatitis B Vaccination Status Form

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

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

Meningococcal vaccine received

Date: ___/___/___

Hepatitis B vaccine received

Dates:

1st Dose ___/___/___

2nd Dose ___/___/___

3rd Dose ___/___/___

Signature (Student/Parent if under 18 years of age):

Date:
