

# LAKELAND COLLEGE HEALTH ASSESSMENT

## RECOMMENDED IMMUNIZATIONS

	mo./day/year	mo./day/year	mo./day/year
Hepatitis B series	(1)	(2)	(3)
Varicella (chicken pox) series of two doses or immunity by positive blood titer	(1)	(2)	Disease Date
Meningococcal			

## MENINGOCOCCAL/HEPATITIS B VACCINE REQUIREMENT

In accordance with Wisconsin State Law

STUDENT NAME: \_\_\_\_\_ Student ID \_\_\_\_\_  
(Social Security No. for domestic students)

To be completed by a health care provider: (Attached documentation of vaccination from a physician or health clinic is also acceptable.)  
The above-named individual has received the Meningococcal and Hepatitis B vaccines as recommended by Lakeland College and the State of Wisconsin for new incoming students.

Date of Meningococcal vaccine administration: \_\_\_\_\_ \*

Dates of Hepatitis B vaccine administration: \_\_\_\_\_

Health care provider name: \_\_\_\_\_ Date: \_\_\_\_\_

Health care provider signature: \_\_\_\_\_ Phone \_\_\_\_\_

## VACCINE WAIVER

To be completed by an individual (or parent/guardian for individual less than 18 years of age) requesting an exemption from the Meningococcal and/or Hepatitis B vaccines requirement:

I have received and read the information in the Meningococcal/Hepatitis B Disease Fact Sheet provided by Lakeland College explaining the risks of Meningococcal and Hepatitis B diseases, and the effectiveness and availability of the Meningococcal and Hepatitis B vaccines. I acknowledge that Meningococcal and Hepatitis B diseases are rare, but life-threatening illnesses. I understand that under Lakeland policy, students enrolled at Lakeland College are recommended to be vaccinated against Meningococcal and Hepatitis B diseases. With this waiver, I seek exemption from this requirement. I voluntarily agree to release, discharge, indemnify and hold harmless Lakeland College, its officers, employees and agents from any and all costs, liabilities, expenses, claims, demands, or causes of action on account of any loss or personal injury that might result from my decision not to be immunized against Meningitis or Hepatitis B.

Name of student: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of student: \_\_\_\_\_

If student is under the age of 18:

Name of parent/guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent \_\_\_\_\_