CALIFORNIA STATE UNIVERSITY, LONG BEACH

STUDENT HEALTH SERVICES

Accredited by the Accreditation Association for Ambulatory Health Care, Inc.
1250 Bellflower Boulevard Long Beach, California 90840-0201 (562) 985-4771

CLEARANCES ONLY
MEASLES AND RUBELLA, HEPATITIS B, MENINGOCOCCAL VACCINE

Student ID: ________________________ **Date of Birth (mm/dd/yyyy):**________________

____ **Gender**: _______

Last Name **First Name** **MI**

Complete sections which apply to you. Show appropriate copies of proof.

MEASLES (RUBEOLA) AND RUBELLA (GERMAN MEASLES) Immunizations after the of age 12 months

O Measles immunization Date:______________ O Rubella immunization Date:____________

O Report of immune titer Date: _____________ O Born before 1957

HEPATITIS B

O DOSE #1Completed Date:_______________ O DOSE #2 Completed Date:____________

O DOSE #3 Completed Date:________________ O Report of immune titer Date: ___________

O 19 years old or older

MENINGOCOCCAL (required of residential hall students only)

O Meningococcal immunization Date:______________

EXEMPTIONS

O It is current medical opinion the contraindications to taking the MMR vaccine are: during pregnancy, within three months of receiving gamma globulin or transfusion or conditions associated with altered immunity such as malignancies, cortisone treatment, seizure disorder and immune deficiencies (e.g. HIV/AIDS). The vaccine is also contraindicated with severe allergic reaction to gelatin, the antibiotic neomycin.

O People should not get **HEPATITIS B** vaccine if they have ever had a life threatening allergic reaction to baker's yeast (the kind used for making bread) or to a previous dose of Hepatitis B vaccine.

O People who are severely or moderately ill at the time the shot is scheduled should wait until they recover before getting **HEPATITIS B or MMR** vaccine

O People should not get **Meningococcal** vaccine if they have a history of a serious reaction (e.g., anaphylaxis) after a previous dose of meningococcal vaccine or to a meningococcal vaccine component. People with history of Guillain Barré syndrome should consult with primary care doctor before receiving the vaccine.

I REQUEST A PERSONAL MEDICAL EXEMPTION – SIGNATURE ______________________________

DATE __________________________

I affirm that medical treatment, including the receiving of immunizations, is contrary to my religious beliefs.

I REQUEST A PERSONAL RELIGIOUS EXEMPTION – SIGNATURE ___________________________

DATE ____________________________

SHS Verified by:____ Date: ___________________________