Hepatitis B Immunization Record

Name: ________________________________ Date of Birth__________________________

KSU ID #________________________________ Phone Number ________________________

KSU E-mail ___________________________ Current Course # _______________________

- Hepatitis B (Series 1): 1. ______/_____/____ 2. _____/______/____ 3. _____/______/____

  * Titer Date: _____/______/____ Positive **<u>or</u>** Negative (*circle 1*)

  (*copy of lab report with values is required*)

- Hepatitis B (Series 2): 1. ______/_____/____ 2. _____/______/____ 3. _____/______/____

  * **Positive** Titer Date: _____/______/____

  (*copy of lab report with values is required*)

Health Care Provider's Signature:____________________________ Date:___/_____/_______

Health Care Provider's Name: (Print) ____

Address:____

Telephone Number: ____