



### 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 **or** 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: \_\_\_\_\_