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: _____