HEPATITIS B VACCINATION REPORT

Student Name (PLEASE PRINT): ____

Please have your physician's office fill out the following or attach documentation.

____________________ ____________________ ____________________
Date 1st Dose Date 2nd Dose Date 3rd Dose

____ ________________________
Nurse's or Physician's Signature Date

Physician or Clinic Address:

____

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Physician or Clinic Phone Number:

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REFUSAL FOR HEPATITIS B VACCINE

I understand that due to my occupation's exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I decline getting the Hepatitis B Vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease.

____________________________________ ___________________________
Signature of Person Refusing Date

____________________________________ ___________________________
Signature of Person Witnessing Date