



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: _____