DREXEL UNIVERSITY
College of Nursing and Health Professions

# HEPATITIS B FORM

## STUDENT INFORMATION

| Last Name: | First Name: | Middle Initial: |
|---|---|---|

| Program: *(please check one)* | ☐ ACE ☐ Co-op ☐ RN-BSN ☐ MSN - NP ☐ MSN – Advanced Role ☐ DrNP ☐ NUAN ☐ PA |
|---|---|
| | ☐ HSAD ☐ HSCI ☐ NS/ISPP ☐ BHC ☐ CFT ☐ CAT ☐ RT ☐ DPT ☐ Faculty |

## Hepatitis B - required

| Vaccination 1st Dose date: | Vaccination 2nd Dose date: | Vaccination 3rd Dose date: |
|---|---|---|

| Date titer completed: *(A positive Hepatitis B surface antibody [HepBsAb or antiHepB] is required for Hepatitis B.)* | Results: (Attach results of laboratory test.) |
|---|---|

| Vaccination provided in accordance with **negative** titer results. | 1st Dose: | If first titer is negative, complete doses 2 and 3. | 2nd Dose: | 3rd Dose: |
|---|---|---|---|---|

## HEALTH CARE EXAMINER'S STATEMENT

I have verified that the individual I have examined is the named individual on this page (5) and that the above tests/vaccinations were performed in this office/laboratory or I have reviewed any documentation relative to the student's immunization record.

| **Examiner's Name (please print)** | |
|---|---|
| **License #:** | **Phone:** |
| **Signature of Health Care Examiner:** | **Date:** |