

HEPATITIS B SECOND IMMUNIZATION SERIES AND SEROLOGY FOLLOW-UP

Last name:	First name:	
Date of birth (yyyy/mm/dd):	Telephone:	
Email:	Year of admission:	Student number:

Program	Nursing	Rehabilitation Sciences	Food and Nutrition Sciences	Human Kinetics
Program	<input type="checkbox"/> Generic program (select campus): <input type="checkbox"/> Ottawa <input type="checkbox"/> Woodroffe <input type="checkbox"/> Pembroke <input type="checkbox"/> Bridging <input type="checkbox"/> Second Entry <input type="checkbox"/> Graduate MScN <input type="checkbox"/> Diploma in PHCNP	<input type="checkbox"/> Audiology <input type="checkbox"/> Speech Language Pathology <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physiotherapy	<input type="checkbox"/>	<input type="checkbox"/>

Primary documentation		
Initial vaccination series:		
Dose 1 (yyyy/mm/dd):	Dose 2 (yyyy/mm/dd):	Dose 3 (yyyy/mm/dd):
Serology (blood work):		
Negative hepatitis B surface antibody result (yyyy/mm/dd):	Negative hepatitis B surface antigen result (yyyy/mm/dd):	

FOLLOW-UP	
<i>To be completed by a health-care provider</i>	
If identified as non-immune (<10IU/L) and HBsAg is negative	
Date of first booster vaccine (yyyy/mm/dd):	
HB surface antibody blood test must be done no earlier than 30 days after vaccine. Attach lab report.	
Anti-HBs	Date (yyyy/mm/dd)
	Result: _____ IU/L
If ≥ 10IU/L, no further action needed If < 10IU/L, continue with complete vaccination series (second and third booster vaccines)	
Date of second booster vaccine (yyyy/mm/dd): (One month after first booster)	
Date of third booster vaccine (yyyy/mm/dd): (Five months after second booster)	
HB surface antibody blood test must be repeated no earlier than 30 days after third vaccine. Attach lab report.	
Anti-HBs	Date (yyyy/mm/dd)
	Result: _____ IU/L
If ≥ 10IU/L, no further action needed.	
If < 10IU/L, no further vaccination. Student must complete Hepatitis B Vaccine Non-Responder Self-Declaration form	

Signature of attesting health-care provider		
Name:	Initials:	Medical clinic stamp:
Address:		
Tel.:	Profession:	
Signature:	Date:	

Email this form to your student placement and experiential learning requirements management adviser at the Faculty of Health Sciences.