

## HUMAN KINETICS: LABORATORY COURSE REQUIREMENTS

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

<b>Laboratory Course</b>	<b>Fall:</b>	<b>Winter:</b>
	<input type="checkbox"/> APA 3114 <input type="checkbox"/> APA 3514	<input type="checkbox"/> APA 2314 <input type="checkbox"/> APA 2714 <input type="checkbox"/> APA 4160 <input type="checkbox"/> APA 4560 <input type="checkbox"/> APA 4315 <input type="checkbox"/> APA 4715

<b>Hepatitis B vaccination and serology (blood test) requirements:</b>			
<b>Part A</b>			
<b>Provide dates of vaccine series</b>			
<b>Dose 1 (yyyy/mm/dd):</b>	<b>Dose 2 (yyyy/mm/dd):</b>	<b>Dose 3 (yyyy/mm/dd):</b>	
<b>Provide date and result of Hep B surface antibody (anti-HBs) AND Hep B surface antigen (HBsAg) test (Attach lab reports)</b>			
Anti-HBs	<b>Date (yyyy/mm/dd):</b>	HBsAg	<b>Date (yyyy/mm/dd):</b>
	Result: _____ IU/L		<input type="checkbox"/> Negative <input type="checkbox"/> Positive
If anti-HBs titer $\geq 10$ IU/L and HBsAg is <b>negative</b> , you are immune. No further action required. If anti-HBs titer $< 10$ IU/L and HBsAg is <b>negative</b> , you are not immune. Proceed to Part B. If anti-HBs titer $< 10$ IU/L and HBsAg is <b>positive</b> , consult a health-care provider and complete a <a href="#">Positive HBsAg Follow-Up form</a> .			
<b>Part B</b>			
<b>If student is identified as non-immune, a booster vaccine and follow up serology for anti-HBs is required.</b>			
<b>Date of booster vaccine (yyyy/mm/dd):</b>			
<b>HB surface antibody blood test must be done no earlier than 30 days after vaccine. (Attach lab report.)</b>			
Anti-HBs	<b>Date (yyyy/mm/dd):</b>		
	Result: _____ IU/L		
If anti-HBs titer $\geq 10$ IU/L, you are immune. No further action is required. If anti-HBs titer $< 10$ IU/L, complete and submit the <a href="#">Hepatitis B Second Immunization Series and Serology Follow-Up form</a> .			

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

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