

Hepatitis B Immunity Statement – Fall 2012

California law requires first-time enrollees at the University of California who are **under** 19 years of age on August 23, 2012 to provide proof of immunization or immunity against the Hepatitis B virus *prior to enrollment*. **Deadline: Wed., August 15, 2012**

Forms should be returned to: **University Health Services/Hepatitis B, 2222 Bancroft Way, Suite 3220, Berkeley, CA 94720-4300** or a copy may be faxed to (510) 642-1801.

Student's Last Name	First name	Middle initial	Date of Birth	Telephone Number
_____ Student Identification Number (8 digit number)			Have you ever been seen at University Health Services before? <input type="checkbox"/> YES <input type="checkbox"/> NO	

SELECT THE ONE CATEGORY THAT APPLIES TO YOU AND COMPLETE AS INDICATED.

You must provide **EITHER** a health care provider's signature and license number **OR** a legible copy of your official immunization record attached to this document.

#1 The above named individual has *completed* the Hepatitis B immunization series on _____ (date)

Healthcare Provider's name (please print) _____

Healthcare Provider's signature _____ License Number _____ Issuing State _____

OR a legible copy of your immunization record attached to this document.

#2 The individual named above has *begun* the Hepatitis B immunization series and has received the following doses: *Please copy this form and return to the above address as each dose is received.*

Dose #1 _____ (date given) Dose #2 _____ (date given)

Healthcare Provider's name (print) _____ Healthcare Provider's Name (print) _____

Healthcare Provider's signature _____ Healthcare Provider's signature _____

License Number _____ Issuing State _____ License Number _____ Issuing State _____

OR a legible copy of your official immunization record attached to this document.

#3 The individual named above has known immunity to Hepatitis B

Healthcare Provider's name (please print) _____

Healthcare Provider's signature _____ License Number _____ Issuing State _____

#4 The above named individual has a medical contraindication to Hepatitis B immunization. *Indicate the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization below:*

Healthcare Provider's name (please print) _____

Healthcare Provider's signature _____ License Number _____ Issuing State _____

#5 Receiving Hepatitis B immunization is contrary to my beliefs

Applicant's signature if 18 years old or an emancipated minor _____

Parent or Guardian's Name (please print) _____ Relationship to student _____

Parent or Guardian's Signature _____

(If the applicant is under 18 years of age and is not an emancipated minor, the parent, guardian or adult who has assumed responsibility for the care and custody of the student must sign).

Questions? Call (510) 642-1804