

Facility Name _____

HEPATITIS B VACCINATION TRACKING FORM
INFECTION CONTROL

Revised: 4/2011

Employee's Name: _____

Job Title: _____

Date of Hire: ____/____/____

Is employee pregnant?..... Yes No

Is employee a nursing mother? Yes No

Is employee allergic to yeast? Yes No

If yes to above, is M.D. note on file? Yes No

Employee has received and reviewed the Hepatitis B Information Sheet?..... Yes No

This employee is cleared by a medical professional to receive the Hepatitis vaccine..... Yes No

Signature of Medical Professional: _____

Side effects of the vaccine have been reviewed with employee by:

Name: _____

Date: ____/____/____

First Injection:

Given: ____/____/____

Site: _____

Manufacturer of vaccine and lot no.: _____

Signature of health care professional: _____

Signature of employee: _____

Second Injection:

Given: ____/____/____

Site: _____

Manufacturer of vaccine and lot no.: _____

Signature of health care professional: _____

Signature of employee: _____

Third Injection:

Given: ____/____/____

Site: _____

Manufacturer of vaccine and lot no.: _____

Signature of health care professional: _____

Signature of employee: _____

Titer:

Post- Immunization Titer Due: _____

Results of Titer: _____

(Titer to be checked 2 months after 3rd shot)

Note: If the employee does not receive his/her vaccine on time, DO NOT, restart vaccination. Just give the remaining vaccinations that are due. If 1st titer is negative give another series of Hepatitis Vaccine and recheck the titer. If second titer is negative there is no further vaccine given.