

**St. Lucie Public Schools  
Employee Hepatitis Immunization Record**

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Present Work Site \_\_\_\_\_ Work Phone \_\_\_\_\_

Allergies \_\_\_\_\_

Clinic Site \_\_\_\_\_

| Date | Employee Signature | Age | Vacc  | MFG/Lot | Signature | Title | Next Appointment |
|------|--------------------|-----|-------|---------|-----------|-------|------------------|
|      |                    |     | Hep B |         |           |       |                  |
|      |                    |     | Hep B |         |           |       |                  |
|      |                    |     | Hep B |         |           |       |                  |

Comments/Notes/Contraindications \_\_\_\_\_

Authorization to Receive Immunization \_\_\_\_\_ Date \_\_\_\_\_

White: Risk Management    Canary: Physician    Pink: Employee

RMD0007

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Allergies \_\_\_\_\_

Clinic Site \_\_\_\_\_

| Date | Employee Signature | Age | Vacc  | MFG/Lot | Authorized DOH Signature | Title | Next Appointment |
|------|--------------------|-----|-------|---------|--------------------------|-------|------------------|
|      |                    |     | Hep B |         |                          |       |                  |
|      |                    |     | Hep B |         |                          |       |                  |
|      |                    |     | Hep B |         |                          |       |                  |

Comments/Notes/Contraindications \_\_\_\_\_

Authorization to Receive Immunization \_\_\_\_\_ Date \_\_\_\_\_

\*Social security numbers are collected, and will only be used, in order to conduct background checks, and, once hired, to process payroll/personnel action, employment benefits, and retirement benefits.

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