STATE OF HAWAII
DEPARTMENT OF EDUCATION

EMPLOYEE HEPATITIS B VACCINATION
Personal Record

Employee’s Full Name: (Print) ________________________________________________

School/Office: _____________________________________________________________

Position: __________________________________________________________________

( ) Completed (First) Hepatitis B vaccination (date) ________________________________
   Kahu Malama Nurse’s signature______________________________________________

( ) Completed (Second) Hepatitis B vaccination (date) ____________________________
   Kahu Malama Nurse’s signature______________________________________________