



**ARMSTRONG ATLANTIC STATE UNIVERSITY**

**COLLEGE OF HEALTH PROFESSIONS**

**HEPATITIS B DECLARATION FORM**

**Print Name on First Line** – Read each option and choose one to sign and date.

Name (Please Print):

- 1. I understand that Hepatitis B is a severe and potentially life threatening illness. Hepatitis B vaccination significantly decreases my risk of being infected by the Hepatitis B virus. Therefore, I agree to take the prescribed series of inoculations and follow-up titer to assess antibody level, and a second series if necessary. I assume responsibility for all arrangements, costs, and complications arising from this vaccination procedure.**

Signature	Date

- 2. I understand that Hepatitis B is a severe and potentially life threatening illness. Hepatitis B vaccination significantly decreases my risk of being infected by the Hepatitis B virus. I understand also that not taking the vaccination may significantly increase my risk of being infected by the Hepatitis B virus. Nevertheless, I elect NOT to take the prescribed vaccination procedure, and assume responsibility for all arrangements, costs, and complications arising from not taking those vaccinations.**

Signature	Date

- 3. I have already received the vaccine (Please attach documentation of shots received)**

Signature	Date

**Return To: Armstrong Atlantic State University  
Medical Technology Dept.  
11935 Abercorn Street  
Savannah, GA 31419-1997  
Fax #: 912-921-5585**