PERINATAL HEPATITIS B PREVENTION CHECKLIST
NORTH DAKOTA DEPARTMENT OF HEALTH
SFN 58460 (Revised 03-2018)

PLEASE PRINT

Child's Name:	Child's Date of Birth:
Provider:	Clinic:
Date of child's next appointment:	
Hepatitis B vaccine (HBV) birth dose and Hepatitis B Immune Globulin (HBIG) Date of HBV #1: _____ Date of HBIG: _____	
HBV second dose due at *1-2 months* of age Date Given: _____	
HBV third dose due at *6 months* of age Date Given: _____	
Post vaccination serologic testing drawn at 9-12 months of age (at least 1-2 months after last dose) **Both tests must be completed at same time* Collection Date:_____ Hepatitis B surface Antigen (HBsAg) ☐ Reactive ☐ Non-Reactive Hepatitis B surface Antibody (anti-HBs) ☐ Immune (positive) ☐ Susceptible (negative)	

Fax this form to: 701.328.0355

If you have any questions, please call:
N. D. Department of Health
Division of Disease Control
2635 East Main Ave.
Bismarck, ND 58506-5520
701.328.2335 or toll-free 800.472.2180