Welcome to Beloit College!

This letter contains important information from the Health Center regarding your health care while attending Beloit College.
REQUIRED OF ALL STUDENTS

PLEASE READ ALL INFORMATION CAREFULLY.

* IMMUNIZATION REQUIREMENTS

PRIOR TO CLASS REGISTRATION AND ARRIVAL ON CAMPUS ALL STUDENTS MUST BE IN COMPLIANCE WITH THE STATE OF WISCONSIN AND THE COLLEGE. ALL entering college students born on or after January 1, 1957 MUST SHOW PROOF OF:

a. Having had 2 doses of MMR vaccine (measles, mumps & rubella)
b. Having had the diseases, measles, mumps & rubella
c. Laboratory evidence of immunity

* THESE DATES MUST BE ENTERED ON THE PHYSICAL RECORD FORM BY THE PHYSICIAN OFFICE. (If you are unable to comply with the above, you must have the immunizations repeated.)

Insurance and emergency information is included with this letter. All information is confidential.

ALL REQUESTED INFORMATION MUST BE COMPLETED AND IN OUR OFFICE BEFORE THE STUDENT WILL BE ALLOWED TO ATTEND CLASSES.

THIS HEALTH FORM IS DUE TO THE OFFICE OF SUMMER PROGRAMS BY APRIL 15.
CAMPUS HEALTH CENTER

All students are encouraged to contact the Health Center for general health care. The Health Center is located on the north side of campus on the first floor of Porter Residence Hall.

Students must be covered by health insurance in order to participate in the program. During the summer, the campus Health Center is open limited hours. Students who need medical attention have two options of support:

- Consultation with the nurse at the Health Center during open hours
- Visiting an off-campus physician with the help of Summer Programs staff (these visits are billed to the student’s health insurance)

During the summer, the Health Center offers:

- Nurse assessment of health problems and injuries
- Health education resources and programs
- Nutrition counseling and information
- Wellness promotion
- Confidential Nurse counseling of health related concerns
- Referral to physician off-campus

During the summer, the Health Center does not have the capacity to take responsibility for the treatment of students’ pre-existing physical and mental health issues. Students with ongoing medical concerns need to be able to manage those health issues on their own, with the exception of emergencies.

HEALTH INSURANCE

1. **Student Medical Expenses are the responsibility of the student** and/or parents. Please check your insurance policy as to the student’s coverage while on campus if illness or injury should occur.

2. **HMO policies may not cover the student.** PLEASE check with your insurance regarding HMO restrictions. We have experienced many problems in getting the needed care for students, especially those out of the insurance service area, due to lack of coverage by HMO’s (i.e. doctors’ appointments, physical therapy, etc.). If this is a problem you may want to consider additional coverage for the student while on campus.

3. **Changes in information:** Insurance, emergency or medical information changes that need updating should be made available to the Health Center. The Health Center may be reached at (608) 363-2331.

4. **MEDICAL, IMMUNIZATION AND INSURANCE INFORMATION MUST BE FILED PRIOR TO THE BEGINNING OF THE SUMMER PROGRAM.** Beloit College will not assume responsibility for filing insurance claims or for medical expenses acquired by the student.

5. Please do not send insurance claim forms to the Health Center. Forms should be in the possession of the student or bills acquired may be sent home for processing.
ALL STUDENTS PLEASE READ
VERY IMPORTANT INFORMATION

In the fall of 2003 the State of Wisconsin passed legislation requiring all college students to be informed about the disease Meningococcal meningitis and hepatitis B. This legislation also requires all colleges to maintain certain records about the vaccination status of students.

We are now required to annually provide you detailed information on the risks associated with Meningococcal meningitis and hepatitis B, and the availability and effectiveness of the vaccines against the diseases. The College must also ensure that each student who resides in on-campus housing affirm that he or she has received this information. Also if they have been vaccinated against either disease, the date of the vaccination must be provided. Finally, we must maintain a confidential record of the affirmations and dates of the vaccines. If you are under the age of 18 this information must be provided to your parent or guardian. This information must be submitted along with your health form and on an annual basis while you are enrolled at the college.

Please read the enclosed information and sign the affirmation paper. Please return this form with your completed Beloit College Health form before your arrival on campus. Failure to return this information will result in a hold being placed your registration. Thank you for your attention to this Wisconsin State Law. If you have questions, please call the health center at 608-363-2331.

If you have ANY questions, please feel free to contact us. We look forward to seeing you this summer on campus. Thank you for your cooperation.

Beloit College, Health Center
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Immunization Policy

Beloit College employs the same immunizations requirements that apply under state law to Wisconsin school students in kindergarten through grade 12. We strictly enforce our policy and permit only limited exceptions. Disease can spread quickly at a small residential college and the College has an interest in protecting individuals and the campus community from the devastating consequence that can result when an adult contracts one of these illnesses.

If a student waives the immunization requirement due to religion, personal conviction or medical contraindications, an Immunization Waiver must be signed and on file in the Health Center prior to enrollment at Beloit College. There are some consequences if immunization(s) is/are waived by the student including quarantine in the event of outbreak of any disease.

A signed waiver must be submitted prior to registration for courses.

Quarantine Policy

Under quarantine policy in the event of an outbreak of any disease for which you are not immunized as required by the college, you will be asked to return home until two incubation periods have passed after the last case has been diagnosed. Students quarantined from campus are not eligible for tuition, room, or board refunds and they may suffer academic consequences if class/lab attendance is necessary to meet course requirements.
IMMUNIZATION WAIVER
(Instructions: If applicable, please sign and return)

I, ________________________, due to religion, personal conviction or medical contraindications, decline the immunization(s) ____________________ required for enrollment at Beloit College. In waiving this (these) immunization(s), I recognize the College’s interest in enforcing this policy for the safety of the college community. I understand that I will be quarantined from campus should an outbreak of the disease(s) for which I have declined immunization occur. I accept full responsibility for waiving these immunizations. I will comply with the policy of quarantine established by the Health Center of Beloit College and will make the arrangements necessary to fulfill my academic obligations. I understand that I will not be entitled to any reimbursement of tuition or other fees associated with my absence from campus as a result of quarantine.

________________________________________________________________________  __________
Student Signature                      Date

________________________________________________________________________  __________
Parent/Guardian Signature             Date
BELOIT COLLEGE
CONFIDENTIAL STUDENT HEALTH HISTORY and MEDICAL RECORD

IMPORTANT: PRIOR to attending classes at Beloit College you MUST: 1. Provide proof of immunity to Measles, Mumps, and Rubella.
2. COMPLETE this form and mail to the Office of Summer Programs by April 15.

Name ___________________________________________ Birthdate: __-__-_______

Cellphone ____________________________________________

Parent(s) or Guardian(s) Name: ____________________________________________________________________________

Home Address _________________________________

number & street     city     state     zip

Home Phone: (_____) _______-_________ Work Phone: (_____) _______-_________

Emergency Contact #1 : Name __________________________ Work phone _________________ Home phone___________

Emergency Contact #2 : Name __________________________ Work phone _________________ Home phone___________

(MUST have TWO MMR 's or proof of immunity as shown below).

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>FIRST DOSE (M/D/Y)</th>
<th>SECOND DOSE (M/D/Y)</th>
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<tbody>
<tr>
<td>MMR (MEASLES, MUMPS, RUBELLA)</td>
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<tr>
<td>MR (MEASLES, RUBELLA)</td>
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<td>MEASLES</td>
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</tbody>
</table>

Having had the above diseases confers lifelong immunity. It is not necessary to have the measles vaccine if you have had the disease.

MEASLES DIAGNOSED BY: ______________________ on ______________________ 20____

RUBELLA: MUST SHOW PROOF FROM LAB REPORT. PHYSICIAN DIAGNOSED RUBELLA IS NOT ACCEPTED.

<table>
<thead>
<tr>
<th>IMMUNIZATION</th>
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<th>2nd DOSE</th>
<th>3rd DOSE</th>
<th>BOOSTER</th>
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<tr>
<td>HEPATITIS A</td>
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<tr>
<td>HEPATITIS B</td>
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<td>POLIOMYELITIS</td>
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<td>DPT</td>
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<td>LAST TETANUS BOOSTER</td>
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<td>MENINGOCOCCAL</td>
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<tr>
<td>VARICELLA</td>
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</table>

Date of Last TB Test:
# MEDICAL HISTORY

**STUDENT'S NAME**

**MEDICAL HISTORY:** Please indicate any condition the student has had or presently has.

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>HAD YES/NO</th>
<th>DATE M/D/Y</th>
<th>HAS NOW</th>
<th>HOW LONG?</th>
<th>HOSPITAL STAY? Y/N</th>
<th>HOW LONG?</th>
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<tbody>
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<td>Arthritis</td>
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<td>Diabetes</td>
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<td>Epilepsy</td>
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<td>Fainting</td>
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<td>Hearing Problems</td>
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<td>Heart Disease/Heart Murmur</td>
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<td>Heat Sensitivity</td>
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<td>Hernia</td>
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<td>High Blood Pressure</td>
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<td>Infectious Mono</td>
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<td>Kidney Infection</td>
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<tr>
<td>Pneumonia</td>
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<td>Rheumatic Fever</td>
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<td>Seizures</td>
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<td>Skin Problems</td>
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<tr>
<td>Strep Throat</td>
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<td>Ulcers or Nervous Stomach</td>
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</table>

Any other serious disease or conditions:

**PLEASE CIRCLE ANY SYMPTOMS THE STUDENT HAS REGULARLY OR FREQUENTLY:**

- Abdominal Pain
- Constipation
- Lack of Appetite
- Shortness of Breath
- Asthma
- Cough
- Migraines
- Spitting Blood
- Back Pain
- Diarrhea
- Muscle cramps/spasms
- Urinary Difficulty
- Bladder infections
- Dizziness
- Nausea &/or Vomiting
- Other: ______________________________
- Bouts of rapid pulse
- Ear infections
- Numbness/Tingling
- Other: ______________________________
- Chest pain
- Frequent Headaches
- Pains in groin area

Women: Menstrual problems

**ALLERGIES:** Please list any and all allergies: (include foods, medicine, environment, etc.)

**Allergies:**

**Sensitivities:**

**CURRENT MEDICATIONS:** (include: name of drug or type of insulin, type of antidepressant, allergy, continuing prescription, etc.; dosage & frequency it is taken)

**Taken for**
MEDICAL HISTORY, continued

| VISION/EYE WEAR: Vision problems or eye conditions: | |
| Contacts: (circle one) | Hard | Gas Permeable | Soft | Glasses: Y N |

| DENTAL APPLIANCE: (If applicable circle one) Y N |
| (i.e.: braces, permanent bridge, crown/jacket, removable plate, full plate) |
| If yes, what? |
| Where is it located? |

| SURGERIES: List any and all types of surgeries (includes dates and, if applicable, results) | |
| EPISODES OF UNCONSCIOUSNESS: How it happened/dates/length of unconsciousness | |

| PREVIOUS SERIOUS INJURIES: FRACTURES; LIGAMENT DAMAGE; ORGAN DAMAGE; ETC. | |

PLEASE USE THE SPACE BELOW IF A CONDITION, ILLNESS, OR MEDICAL TREATMENT NEEDED REQUIRES A MORE DETAILED EXPLANATION. FEEL FREE TO ATTACH A SEPARATE PIECE OF PAPER.

| FAMILY HISTORY: Please note relative who has/had any of the following conditions: |
| Bleeding tendencies | Epilepsy | |
| Heart Disease | Ulcers | |
| Kidney Disease | Cancer | |
| Diabetes | Arthritis | |
| High Blood Pressure | Other: | |
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PERMISSION FOR TREATMENT

I. Medical Treatment/Medication:
Permission is hereby granted to attending medical personnel to dispense medication and provide needed medical or surgical treatment, x-ray examinations, and immunizations for:

Student Name: ____________________________

In the event of serious illness or injury, or the need for major surgery, I understand that an attempt will be made by a physician or the College to contact the parent, guardian or other designated contact. If said physician or College is unable to communicate with them, the necessary treatment for the above student may be given. (A parent or guardian MUST sign if student is under 18 in order for medical treatment to be given. If statement is not signed, the hospital/doctor MUST first get permission from the parent/guardian before medical treatment can be given.)

Signature of Student ____________________________ Date ____________

Signature of Parent/Guardian ____________________________ Date ____________

CONFIDENTIALITY STATEMENT: This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
At the Beloit College Health Center your personal health information is kept confidential. You must give written permission for it to be shared with any medical provider outside of the Health Center or the Beloit Physician Hospital Organization. The BPHO provides campus physician services and our laboratory and x-ray services.
You will need to sign a release of medical information if your records or personal health identification are to be shared outside of the providers as stated above.
When you use the services of the above you will be asked to sign a release for billing purposes.
A log will be placed inside your chart for you to review that will state when and with whom your PHI was shared and an area that indicates whether your signature was necessary.
Your health center file will be marked with a red confidential sticker.
You will be asked to read the preceding statement and sign that you have read the information. This will also be placed in your chart.

I, ____________________________________________, have read and understand the above statement.

Signature ____________________________________________ Date ____________________________

INSURANCE COVERAGE INFORMATION

Primary Policy Holder:

Insurance Type: (circle one) HMO 90-day College Student Plan Other

My insurance plan allows for my student to be treated in the Beloit community: Yes ___ No ___

Restrictions: ____________________________________________

Insurance Company Name: ____________________________ Insurance Phone Number: ____________________________

Address: ____________________________________________

Number & Street ____________________________ City ______ State ______ Zip ______

Policy Number: ____________________________ I.D.# ____________

Other Coverage or Info ____________________________________________

Policy Belongs to: (circle one) Parent/guardian Student

Student Signature ____________________________________________ Date ______ / ______ / ______

If the insurance is through a parent(s), then a parent(s) signature is required.

Parent Signature _________________________________________ Date ______ / ______ / ______
Dear Students,

The State of Wisconsin has passed legislation requiring all college students to be informed about the diseases meningococcal meningitis and hepatitis B. This legislation also requires all colleges to maintain certain records about the vaccination status of students.

We are now required to annually provide you detailed information on the risks associated with meningococcal meningitis and hepatitis B, the availability and effectiveness of vaccines against the diseases. The College must also ensure that each student who resides in on-campus housing affirms that he or she has received this information and, if they have been vaccinated against either disease, provide the date of the vaccination. Finally we must maintain a confidential record of the affirmations and dates of the vaccinations. If you are under the age of 18 this information must be provided to your parent or guardian. This information must be obtained prior to the beginning of this semester and on an annual basis while you are enrolled in college.

Failure to provide and return this information will result in a hold on your semester registration.

1. Please read the attached information concerning meningococcal meningitis and hepatitis B.
2. Please sign and date the attached form and if you have received the vaccines, please indicate the dates in the area below.

This information will be added to your confidential health record that is kept in the health center.

I, __________________________ have read the attached information on ____________
(please print)          (date)

Signature required _________________________________

Please fill in the required information below and return this form to the Office of Summer Programs.

I have not received vaccination against Hepatitis B __________
I have received the three vaccinations against Hepatitis B __________
The dates of my vaccinations are 1._______, 2._______, 3._______
I have not received vaccination against Meningococcal Meningitis. __________
I have received the vaccination for Meningococcal Meningitis. __________
The date of the vaccination is ____________
What is meningococcal disease?
Meningococcal (me-ning'go-kok'al) disease includes meningococcal meningitis and meningococcemia (me.ning'go-kok-se'me-a). Meningitis is an inflammation of the meninges (me-nin' jez), the tissues that cover the brain and spinal cord. Meningococcal meningitis is a severe form of meningitis caused by the bacterium Neisseria meningitidis. Meningococcemia is an infection of the blood with Neisseria meningitidis.

What are the symptoms?
The signs and symptoms of meningococcal disease can vary widely. Fever, headache, vomiting, stiff neck and a rash are common signs and symptoms of meningococcal meningitis. People with meningococcemia often develop a fever, rash, headache and weakness. A person may have either meningococcal meningitis or meningococcemia, or both at the same time.

How soon do the symptoms appear?
The symptoms may develop rapidly, sometimes in a matter of hours, but usually over several days. In some cases, death may occur within hours of the onset of Symptoms. The symptoms may appear anytime between 2 and 10 days after exposure, usually within 3 to 4 days.

Who gets meningococcal disease?
Most people exposed to Neisseria meningitidis do not become seriously ill. Anyone can get meningococcal disease, but it is more common in children and young adults. Compared to other persons their age, college freshmen, especially those who live in dormitories, are at modestly increased risk for meningococcal disease.

How is the bacteria that causes meningococcal disease spread?
The meningococcus bacterium is spread by direct, close contact with respiratory and oral secretions (saliva, sputum or nasal mucus) of an infected person. Close contacts include household members, day care center contacts and anyone directly exposed to the patient's oral or nasal secretions. Many people carry this bacterium in their nose and throat without any signs of illness, while others may develop serious symptoms.

When and for how long is an infected person able to spread the disease?
A person may transmit the disease from the time he/she is first infected until the bacteria are no longer present in discharges from the nose and throat. The duration varies according to treatment used. Patients should be excluded from school, daycare or the work place until at least 24 hours after therapy was begun and the illness has subsided.

What is the treatment for meningococcal disease?
Penicillin is the drug of choice for meningococcal disease, while third generation cephalosporins are reasonable alternatives.

Should people who have been in contact with a person with a diagnosed case of meningococcal disease be treated?
Only people who have been in close contact need to be considered for preventive treatment. Close contacts include household members, intimate contacts (i.e. kissing), persons performing mouth to mouth resuscitation or endotracheal intubation, day care center contacts, or anyone directly exposed to the patient's oral or nasal secretions. Such people are usually advised to take preventive antibiotics, such as rifampin, ciprofloxacin or ceftriaxone. Casual contact that might occur in a regular classroom, office or factory setting is not usually significant enough to cause concern. Close contacts (family, daycare, nursery school, etc.) should be alerted to watch for early signs of illness, especially fever, and seek treatment promptly.

Is there a vaccine to prevent meningococcal disease?
Presently, there is a vaccine that will protect against four of the serogroups of meningococcus. It is recommended in some outbreak situations or for travel to areas of the world where high rates of the disease are known to occur. College freshmen should consider receiving the vaccine to decrease their risk of acquiring the disease.
**Hepatitis B (serum Hepatitis)**

**What is hepatitis B?**
Hepatitis B (formerly known as serum hepatitis) is a liver disease caused by the hepatitis B virus (HBV). The disease is fairly common; about 75 acute cases and 500 chronic/unspecified cases are reported in Wisconsin each year.

**Who is most likely to get hepatitis B?**
- Injection drug users
- Healthcare workers
- Homosexual men
- Heterosexuals with multiple partners
- Hemodialysis patients
- Sexual/household contacts of infected people
- Infants born to infected mothers
- Infants/children of immigrants from HBV-endemic countries

**How is the virus spread?**
HBV is spread by contact with blood, serum, semen, vaginal fluids and, rarely, saliva. Direct contact with infected body fluids; usually by needle stick injury, sharing needles, or sexual contact, is necessary for spread. HBV is not spread by casual contact or by respiratory droplets.

**What are the symptoms of hepatitis B?**
The symptoms of hepatitis B include fatigue, poor appetite, nausea, vomiting, abdominal discomfort and sometimes joint pain or rash. Later, urine may become dark and jaundice, a yellowing of the skin and whites of the eyes) may appear. Many people do not have typical symptoms of hepatitis; only 10% of children and 30-50% of adults develop jaundice.

**When do symptoms appear?**
Symptoms usually appear 2-3 months after exposure (range: 1 ½ - 6 months).

**How long can a person spread the virus?**
HBV is present in blood and other body fluids several weeks before symptoms appear and usually persists for about 3 months. However, the likelihood of complete recovery with elimination of the virus from the body depends on the age when infection occurs.

Chronic infection occurs in 80-90% of infants infected during the first year of life, in 30-50% of children infected between 1-4 years of age and in 5-10% of people infected after 6 years of age. People with chronic hepatitis B may infect others and 15-25% may die prematurely of either cirrhosis or liver cancer.

**What is the treatment for hepatitis B?**
There are no special medicines or antibiotics that can be used to treat a person once symptoms of acute hepatitis appear. Currently, alpha interferon is the only drug licensed to treat chronic hepatitis B. Treatment is recommended only for patients who have liver biopsy evidence of chronic hepatitis B. About 40% of patients respond to treatment. Other drugs are currently being developed to treat chronic hepatitis B that may become available in the future.

**What precautions should a person with acute or chronic hepatitis B take?**
The person should follow standard hygienic practices to protect close contacts from blood and other body fluids. The infected person must not share razors, toothbrushes, needles, or any other object that may have become contaminated with blood. Use of latex condoms during sexual activity may reduce transmission of HBV among homosexuals and heterosexuals. The infected person must not donate blood and should inform dental and medical care providers so that proper precautions can be followed.

**How can hepatitis B be prevented?**
Hepatitis B can be prevented either before or right after exposure to the virus. To prevent disease before exposure, hepatitis B vaccine is recommended for all infants, all 11-12 year-olds, people in high risk occupations (e.g., healthcare workers) and people with a high risk behavior (e.g., injection drug use or multiple sexual partners). Susceptible sexual and household contacts of people with chronic hepatitis B should also be immunized and the sexual partners should be tested for immunity after they complete the 3-dose series.

To prevent disease after exposure, hepatitis B immune globulin (HBIG) is given along with hepatitis B vaccine.

- Infants of infected mothers. Because these infants are exposed to the virus during labor and delivery, all pregnant women should be screened for hepatitis B prenatally. Infants of women who test positive should receive HBIG and the first dose of hepatitis B vaccine within 12 hours of birth. The infant should receive the remaining doses of hepatitis B vaccine at 1-2 months and 6 months of age.
- Sex partners of a person with acute hepatitis B should be given HBIG within 2 weeks of the last sexual contact.
- Household contacts of a person with acute hepatitis B do not need HBIG unless they have had a blood exposure to the case within the past 2 weeks. Questions about preventing hepatitis B after other types of exposures should be directed to your physician or local health department.

DEVELOPED BY THE DIVISION OF PUBLIC HEALTH.
BUREAU OF COMMUNICABLE DISEASE
IMMUNIZATION PROGRAM
PPH 42055 6/99