

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Last Name (print)                      First Name                      Date of Birth                      Student ID

To be completed and signed by a physician, health care provider, or clinic. You may attach signed record.  
Signature of Physician's      Signature or Health Care Provider      Clinic      Date

_____ Address	_____ Phone Number
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**Hepatitis B Vaccination Waiver**

I understand that due to exposure to blood, body fluids, or other potentially infectious materials I encounter in my nursing student activities, I will be at risk for acquiring a Hepatitis B viral infection. I further understand that the Hepatitis B vaccine typically reduces the chances of developing the infection, a serious and possibly life-threatening disease. However, I choose to waive the requirement of the Hepatitis B Vaccination and will not hold Gardner-Webb University or any clinical agency responsible in the event I am exposed to or contract Hepatitis B.

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Signature of Student (Parent or Guardian if under the age of 18)                      Date