HEPATITIS B RISK ASSESSMENT

TO BE COMPLETED BY PARENT OR GUARDIAN

Name of Child _____

Date of Birth _____ Sex _____

Address _____

Telephone Number _____

School Attending _____

TO BE COMPLETED BY A PHYSICIAN

A. Test Results

	Positive	Negative	Date
hepatitis B surface antigen			
hepatitis B e antigen			
hepatitis B surface antibody			

B. Does this child suffer from any of the following medical problems?

	Yes	No
bleeding disorders		
hypertrophied gums		
oozing skin lesions		
menstrual problems		
fits or seizures		

C. Does this child display any of the following behaviors?

	Yes	No
biting		
scratching		
excessive drooling		
self mutilations		
aggressive behaviors		

D. Does this child suffer from any other medical problems that might increase their likelihood of spreading hepatitis B? (please specify)

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