KY Hepatitis Connections

Inside our June 2015 edition of the KY Hepatitis Connections you will find informationabout viral hepatitis, opportunities for viral hepatitis continuing professional education, and information about educational materials available. See all the exciting things happening here in Kentucky!

If you would like to share your favorite Kentucky landscape pictures for readers of our newsletter, send them to me. As always, feel free to forward, copy and/or distribute this newsletter to other professionals in your network. Your knowledge and input are greatly valued, as we are committed to keeping you up to date on shared progress in the medical community on viral hepatitis and its impact on our families throughout the Commonwealth. We hope you enjoy the June newsletter.

Kathy Sanders, RN, MSN

Morbidity and Mortality Weekly Report (*MMWR*)

Increases in Hepatitis C Virus Infection Related to Injection Drug Use among Persons Aged ≤30 Years — Kentucky, Tennessee, Virginia, and West Virginia, 2006–2012

May 8, 2015/ 64/17); 453-458 Hepatitis C virus (HCV) infection is the most common blood-borne infection in the United States, with approximately three million persons living with current infection (*1*). Percutaneous exposure to contaminated blood is the most efficient mode of transmission, and in the United States, injection drug use (IDU) is the primary risk factor for infection. State surveillance reports from the period 2006–2012 reveal a nationwide increase in reported cases of acute HCV infection, with the largest increases occurring east of the Mississippi River, particularly among states in central Appalachia (*2*). Demographic and behavioral data accompanying these reports show young persons (aged ≤30 years) from nonurban areas contributed to the majority of cases, with about 73% citing IDU as a principal risk factor. To better understand the increase in acute cases of HCV infection and its correlation to IDU, CDC examined surveillance data for acute case reports in conjunction with analyzing drug treatment admissions data from the Treatment Episode Data Set-Admissions (TEDS-A) among persons aged ≤30 years in four states (Kentucky, Tennessee, Virginia, and West Virginia) for the period 2006–2012. During this period, significant increases in cases of acute HCV infection were found among persons in both urban and nonurban areas, with a substantially higher incidence observed each year among persons residing in nonurban areas. During the same period, the proportion of treatment admissions for opioid dependency increased 21.1% in the four states, with a significant increase in the proportion of persons admitted who identified injecting as their main route of drug administration (an increase of 12.6%). Taken together, these increases indicate a geographic intersection among opioid abuse, drug injecting, and HCV infection in central Appalachia and underscore the need for integrated health services in substance abuse treatment settings to prevent HCV infection and ensure that those who are infected receive medical care.

Confirmed cases of acute HCV infection* and associated demographic and risk characteristics were obtained from the National Notifiable Disease Surveillance System (NNDSS) for Kentucky, Tennessee, Virginia, and West Virginia for the period 2006–2012 for persons aged ≤30 years.† Surveillance case reports met the clinical and laboratory markers of confirmed cases of acute HCV infection as defined by CDC/CSTE.§ A case report was classified as "urban" if the person lived in a metropolitan county with ≥50,000 population and as "nonurban" if the person lived in a nonmetropolitan county with <50,000 population.¶ The percentage of cases reported for the period 2006–2012 among persons aged ≤30 years in the four states were examined by demographic and risk characteristics (IDU versus non-IDU) and by urbanicity. In addition, using the number of cases reported through NNDSS as the numerator and the mid-year (July) population estimates for persons aged ≤30 years from U.S. Census Bureau as the denominator, annual incidence rates for the period 2006–2012 were calculated and analyzed by urbanicity. Linear trends in annual incidence were determined by the Spearman correlation trend test and were considered statistically significant at $p<0.05$

Read More: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6417a2.htm?s_cid=mm6417a2_e

In the News:

Intravenous drug use in rural Kentucky carries risk of explosion of HIV

By Mary Meehan

A small town in rural Indiana had more needle-using drug users infected with HIV this year than New York City, according to the Centers for Disease Control and Prevention.

The same thing could happen in Kentucky.

A drug-fueled HIV outbreak infecting 160 people in Austin, Ind. — population 4,200 — is shocking the nation. But it didn't surprise University of Kentucky researcher Jennifer Havens.

The infection rates in Austin, which continue to rise incrementally, rival those of HIV-ravaged areas of sub-Saharan Africa, according to the CDC.

"There are a lot of the same ingredients (in Kentucky) that are behind what is going on in Indiana," said Havens, who has followed 500 drug abusers in Eastern Kentucky since 2008 for UK's Center on Drug and Alcohol Research.

The appearance of a drug-using HIV patient in Eastern Kentucky, a "patient zero," is what Havens dreads.

HIV rates have traditionally been low in rural parts of the state. But once HIV enters rural drug-using communities, it will spread quickly, she said.

As in Scott County, Ind., where the outbreak was the worst in state history, rural Kentucky has interconnected groups of intravenous drug users sharing needles and having sex, and often trading sex for money or drugs.

"There are often dense networks of people" existing in areas with limited treatment options and the lingering stigma of HIV as a disease of homosexuals, Havens said.

Read more here: http://www.kentucky.com/2015/05/23/3866302/intravenous-drug-use-in-rural.html#storylink=cpy

Lexington needle-exchange program for drug users on track for August approval, health board says

The Urban County Council probably will be asked by August to approve a needle-exchange program aimed at stemming growing rates of hepatitis and HIV in Fayette County.

"We don't expect much pushback" from the council, Scott White, chairman of the Lexington-Fayette County Board of Health, said during a meeting Monday evening.

But, he said, the board and health department will need to educate the council and the public about the need for and safety of a needle-exchange program because it does involve illegal activity — drug use.

Rates of hepatitis B and C and HIV have climbed dramatically in the past three years as heroin use has skyrocketed in Lexington and across Kentucky.

Dr. Rice Leach, the health commissioner, said the public health benefits of a needle-exchange program extend beyond intravenous users. Hepatitis C and B and HIV, the main targets of the program, also are transmitted sexually, he said. Those diseases are being spread to people who don't use drugs and further out into the community, he said.

A law passed by the state legislature in March allows Kentucky health departments and local governments to create needle-exchange programs. The health departments in Louisville and Northern Kentucky also are working on programs, Leach said.

But, he said, "It is not so much that we need to be first. We need to do this thing right."

He and his staff are working with infectious disease specialists at the University of Kentucky, people who deal with mental illness at Bluegrass.org and law enforcement and other groups who come into regular contact with intravenous drug users to nail down specifics of the program.

Read more here: http://www.kentucky.com/2015/05/11/3846892_lexington-needle-exchange-program.html?rh=1#storylink=cpy

Injection Drug Use Fuels Rise in Hepatitis C Cases

The rise in injection drug use across the country, especially the eastern U.S., is fueling an outbreak of hepatitis C. Outreach workers are offering clean needles and testing to contain the spread.

An outbreak of HIV in southeastern Indiana drew the attention of public health experts, media, and lawmakers. Most of the cases are linked to sharing needles to inject drugs. And we're going to hear about another epidemic that injection drug use is fueling. From Rhode Island Public Radio, Kristin Espeland Gourlay reports on the growing threat of hepatitis C.

KRISTIN ESPELAND GOURLAY, BYLINE: All it takes is contact with a tiny drop of blood - even a microscopic smear of blood can be teaming with the hepatitis C virus. That's why sharing a needle or other paraphernalia to inject drug spreads hepatitis C. It's much more contagious than HIV. Brown University epidemiologist Brandon Marshall studies patterns of drug abuse and infectious disease.

BRANDON MARSHALL: So if someone starts injecting, they have about a 50 percent chance of becoming infected with hepatitis C within three years, so that's a very high risk of infection.

GOURLAY: Plus, more Americans are injecting drugs than they did 10 years ago. Many got hooked on painkillers like Vicodin then turned to something similar but cheaper - heroin. Marshall says today's younger injection drug users might not know they're at risk, but that risk is becoming reality. The Centers for Disease Control and Prevention reports 150 percent increase in new hep C cases nationwide just in the past three years - triple that in some pockets of the country. The disease now kills more people than HIV, but it doesn't have to. That's the message Arien Daly and Keith Thompson deliver every Tuesday when they pull their yellow van into this noisy church parking lot. They're with a small nonprofit called AIDS Care Ocean State, and we're in a small town in northern Rhode Island. Like many others, it's been ravaged by opioid addiction.

GOURLAY: This is John Ward, head of the CDC's division of viral hepatitis.

WARD: It's just there should be an equal sense of urgency regarding these epidemics of hepatitis C around the country.

GOURLAY: Ward says he and his colleagues are just beginning to get a handle on the true scope of the problem, but the very nature of the disease makes it tough. First, most people have no idea when they get infected

WARD: They don't even seek medical attention. If they do, the health care provider may not order a test to detect that infection, and then those cases may not be reported to the health department or on to CDC

To listen to story or read more, go to: http://www.npr.org/2015/05/26/409804741/injection-drug-use-fuels-rise-in-hepatitis-c-cases

Oral agents can lead to a gain of billions of dollars in work productivity

WASHINGTON -- Treating genotype 1 (GT1) chronic hepatitis C (CHC) patients with ledipasvir/sofosbuvir (Harvoni) would result in an annual societal productivity gain of approximately $2.7 billion in the U.S.,

The productivity gain in the EU-5 (France, Germany, Italy, Spain, and the U.K.) would be $435 million per year, reported Zobair Younossi, MD, MPH, of Inova Fairfax Hospital in Falls Church, Va., and colleagues, at the Digestive Disease Week annual meeting.

The difference between U.S. and EU-5 savings "has to do with larger number of HCV [hepatitis C virus] GT1 patients in the U.S., as well as the difference in labor cost," such as number of hours worked and pay per hour, Younossi told MedPage Impairments in CHC patients cost $7.1 billion in the U.S. and $2.6 billion in the EU-5 due to decreased productivity, Younossi said.

While previous studies have discussed the high cost of oral hepatitis C drugs, "the long-term benefit of curing hepatitis C makes this type of treatment a worthwhile investment," he said. "These economic gains could partly offset the cost related to the widespread treatment with the new all oral anti-HCV regimens to cure HCV with excellent efficacy, safety, and improvement of [patient-reported outcomes]."

The economic benefits of curing hepatitis C can be significant, agreed Marc Ghany, MD, a staff clinician at the NIH's National Institute of Diabetes and Digestive and Kidney Diseases in Bethesda, Md. There hasn't been much research in this particular area, he added. Gilead's Harvoni (ledipasvir-sofosbuvir) costs $1,125 per pill, or $94,500 for a 12-week course of treatment. Read More: http://www.medpagetoday.com/MeetingCoverage/DDW/51581?xid=nl_mpt_IDSA_confreporter_2015-05-18&eun=g5517831d30r

Narcan Kits to be distributed to fight heroin

COVINGTON, Ky. (Jeff Hirsh) -- Calling northern Kentucky “ground zero” in the state's heroin problem, the attorney general, and the Commonwealth's first lady Tuesday, May 26, kicked-off a program aimed at preventing heroin users from dying.

A drug used in hospitals and by first responders is now available to overdose survivors. As Attorney General Jack Conway announced, the St. Elizabeth hospital system will be getting Narcan kits to distribute. Noel Stegner was in the audience and grateful for what he heard, “In Kentucky today there's probably no more harmful nor tragic drug than heroin.” Narcan is already used in hospitals. The medication almost immediately reverses a heroin overdose. The kits contain Narcan nasal spray. Of course, it's mostly relatives or friends who will administer Narcan to an overdose victim because the victim will not be in a condition to do so. The five-hospital St. Elizabeth chain in northern Kentucky will be getting 500 Narcan kits. That may sound like a lot, but this year they are on a pace to have 1,100 overdose cases admitted to the hospitals. And while Narcan is important, it's just one step. Most people in northern Kentucky may indeed hate heroin but too many are still using it. There were 11 overdoses in Covington alone the weekend before last. At least now, many of those users will at least be around for a shot at recovery.

Read More: http://www.local12.com/news/features/top-stories/stories/Narcan-kits-to-be-distributed-to-fight-heroin-epidemic-140746.shtml

Recommendations for Testing, Managing, and Treating Hepatitis C

New direct-acting oral agents capable of curing hepatitis C virus (HCV) infection have been approved for use in the United States. The initial direct-acting agents were approved in 2011, and many more oral drugs are expected to be approved in the next few years. As new information is presented at scientific conferences and published in peer-reviewed journals, health care practitioners have expressed a need for a credible source of unbiased guidance on how best to treat their patients with HCV infection. To provide healthcare professionals with timely guidance, the American Association for the Study of Liver Diseases (AASLD) and the Infectious Diseases Society of America (IDSA) in collaboration with the International Antiviral Society–USA (IAS–USA) have developed a web-based process for the rapid formulation and dissemination of evidence-based, expert-developed recommendations for hepatitis C management. New sections will be added, and the recommendations will be updated on a regular basis as new information becomes available. An ongoing summary of "recent changes" will also be available for readers who want to be directed to updates and changes.

An estimated 3 million to 4 million persons in the United States are chronically infected with HCV, and approximately half are unaware of their status. These individuals may ultimately progress to advanced liver disease and/or hepatocellular cancer. However, those outcomes can be prevented by treatment, which is rapidly improving and offers the potential of a cure to more patients than has been previously possible. Refer to: http://www.hcvguidelines.org/

FDA Grants Breakthrough Therapy Designation for Genotype 1 Hepatitis C Therapy

The daclatasvir-sofosbuvir regimen for the treatment of genotype 1 hepatitis C patients was granted amended Breakthrough Therapy Designation by U.S. Food and Drug Administration (FDA). In the beginning of 2015, the FDA had planned to remove Breakthrough-Therapy Designation for the daclatasvir-sofosbuvir treatment since other therapies were available and had higher success for other genotypes. However, the FDA revised its first decision and decided to continue the development of this therapy for the genotype 1 hepatitis C patients addressed in ALLY-1 Trial due to its promising results.

Genotypes are strains of a disease, such as hepatitis C. There are many subtypes of the hepatitis C virus according to geographic regions where the strain is most predominant. With time, each strain develops differently so that therapies are chosen dependent on the genotype of the disease. In the United States, Genotype 1 is the most frequent hepatitis C strain and most difficult to treat

The Phase III Daclatasvir, Sofosbuvir, and Ribavirin in Cirrhotic Subjects and Subjects Post-liver Transplant (ALLY 1) was a study involving 12-week oral treatment of daclatasvir and sofosbuvir once a day with ribavirin for the therapy of patients with the genotype 1 strain of hepatitis C. In this study, the enrolled individuals either had advanced cirrhosis (scarring of the liver) or have had a liver transplant but hepatitis C has reappeared. The study findings demonstrated 94% and 83% of cure, respectively, for patients with a liver transplant and returning hepatitis C, and patients with advanced cirrhosis.

Read More: http://hepatitisnewstoday.com/2015/05/26/fda-grants-breakthrough-therapy-designation-genotype-1-hepatitis-c-therapy/

Local Health Departments and Hepatitis C

Hepatitis C virus (HCV) infection, the most common chronic bloodborne infection in the United States, presents significant challenges to the public health and healthcare system. Local health departments play an important role in addressing these challenges and serving impacted populations in their communities. Local health departments offer leadership and support across the continuum of HCV prevention, care, and treatment and are on the frontlines of new opportunities to expand HCV testing, care, and treatment. However, resources and capacities to address HCV are limited.

To support local health departments and their partners, NACCHO developed an educational series to increase knowledge of HCV-related topics, provide information and examples of how local health departments can leverage existing resources to address HCV, and share successful local health department practices and policies for expanding HCV-related services in their communities. The educational series was launched on May 1, 2015 to mark National Hepatitis Awareness Month. Additional educational modules, resources, and tools will be added throughout the year.

Module 1- Hepatitis C Virus: An Overview and Introduction to the Role of Local Health Departments

- **Hepatitis C: Where Are We Now?** (Presented by John W. Ward, M.D., Division of Viral Hepatitis, CDC)
- **The National Viral Hepatitis Action Plan** (Presented by Corinna Dan, RN, MPH, Office of HIV/AIDS and Infectious Disease Policy, HHS)
- **Viral Hepatitis C Testing Recommendations for Persons Born 1945-1965** (Presented by Claudia Vellozzi, M.D., MPH, Division of Viral Hepatitis, CDC)
- **Leveraging Partnerships to Address Hepatitis C: Philadelphia's Model** (Presented by Alex Shirreffs, MPH, Viral Hepatitis Prevention Coordinator, Philadelphia Department of Public Health)

Read More: http://naccho.org/topics/HPDP/hepatitis-c.cfm?utm_source=MagnetMail&utm_medium=email&utm_term=margaretc.jones@ky.gov&utm_content=2015%5F05%5F19CONNECT&utm_campaign=NACCHO%20Connect%2C%20May%2019

Harvoni Safe and Effective for Cirrhotic Patients

Perfect response rates with 24 weeks Harvoni plus ribavirin.

Combination therapy with ledipasvir-sofosbuvir (Harvoni) was safe and effective for patients with chronic hepatitis C (HCV) genotype 1 and compensated cirrhosis, researchers reported here.

Results of a pooled analysis found that out of 513 patients, a total of 96% achieved a sustained viral response at 12 weeks (SVR12), reported K. Rajender Reddy, MD, director of hepatology at the Hospital of the University of Pennsylvania in Philadelphia, and colleagues at the Digestive Disease Week annual meeting.

The regimens were effective in patients regardless of whether they had baseline HCV NS5A resistance-associated variants (RAVs), Reddy said.

"This is a significant improvement for patients with cirrhosis," Jonathan Fenkel, MD, a gastroenterologist and director of the Jefferson Hepatitis C Center at Thomas Jefferson University Hospital in Philadelphia who was not involved in the study, told MedPage Today.

"Hopefully these medications can allow us to prevent the need for transplant for some patients with hepatitis C and increase access to transplant for patients with nonviral liver disease," Fenkel added.

Historically patients with cirrhosis have been difficult to treat, said Marc Ghany, MD, a staff clinician at the NIH's National Institute of Diabetes and Digestive and Kidney Diseases in Bethesda, Md. who was not involved in the study.

Read More:
http://www.medpagetoday.com/MeetingCoverage/DDW/51605?xid=nl_mpt_IDSA_confreporter_2015-05-19&eun=g5144505d30r

Weighing the Wisdom of Expanded HCV Screening

Many organizations, including the CDC, have endorsed expanding widespread screening for hepatitis C virus, but experts writing in *The BMJ* warn that physicians should resist screening until more evidence on the risk-benefit ratio and long-term clinical improvements with antiviral therapy becomes available.

Expanding screening for hepatitis C to the entire population of persons born between 1945 and 1965 is based on two unproven assumptions: that the benefits of treatment of screen-detected persons will outweigh the harms, and that the 3- or 6-month surrogate outcomes (viral suppression) observed in trials of new treatments will translate into long-term reductions in morbidity and mortality from liver disease," Kenneth W. Lin, MD, MPH, associate professor of family medicine at Georgetown University School of Medicine, told *Healio Gastroenterology*. "We need more data to support these assumptions before recommending or mandating that primary care physicians like me start indiscriminately testing millions of older adults."

The CDC, however, is holding firm in its position, according to **John Ward, MD,** director of the Division of Viral Hepatitis in the CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. "We believe it is critical that everyone with hepatitis C know their status, have access to effective care, and discuss with their provider whether treatment is right for them," he said. "Nearly 3 million Americans are infected with hepatitis C, and at least half don't know it — and, therefore, don't realize that their livers are slowly and silently being damaged."

Read More: http://www.healio.com/gastroenterology/hepatitis-c/news/print/healio-gastroenterology/%7Bc4ba18fa-ca9e-4ed6-8fa3-d2d52a33420c%7D/weighing-the-wisdom-of-expanded-hcv-screening?utm_source=maestro&utm_medium=email&utm_campaign=gastroenterology+news

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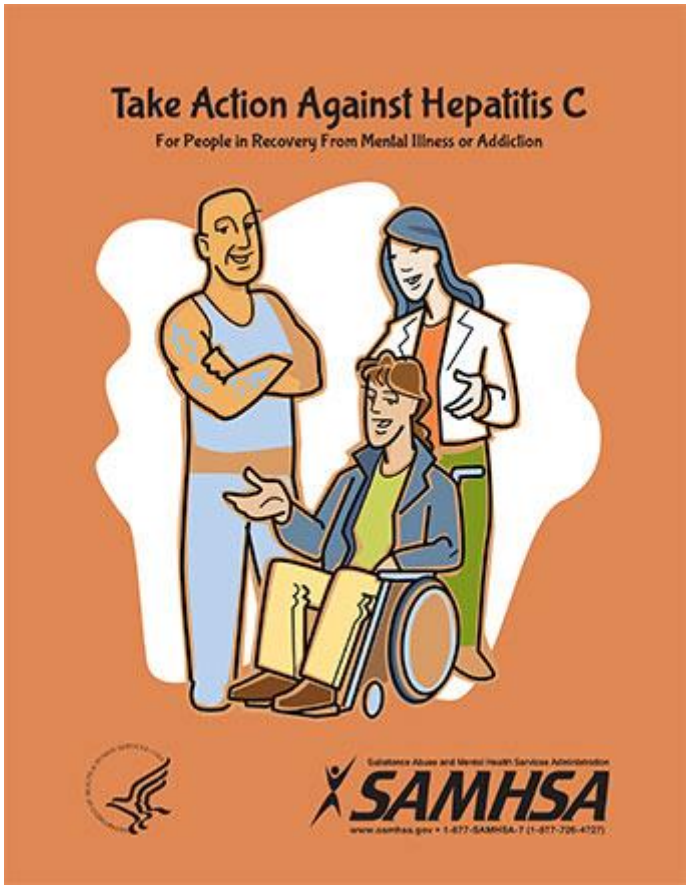

The Take Action Against Hepatitis C from SAMHSA presents basic information about hepatitis C for people with mental illness or substance use disorders. Uses plain language and a simple cartoon style to explain what hepatitis C is, how to avoid it, what's involved with screening, and treatment options.

To Order go to: http://store.samhsa.gov/product/Take-Action-Against-Hepatitis-C/SMA14-4853?WT.mc_id=EB_20150507_SMA14-4853

FREE TRAINING!

The 2015 Kentucky Conference:

Hepatitis: Preventing The Silent Epidemic in Kentucky

Embassy Suites in Lexington, Kentucky

July 28, 2015

This conference aims to educate attendees on prevention, diagnosis, and treatment of those affected by hepatitis B and hepatitis C.

Breakfast, snacks, and lunch provided

FREE- CEU and CME Credits

Registration: https://ky.train.org

Course ID: #1056815

Hotel information: https://aws.passkey.com/event/13886834/owner/11575814/home

For more Information, email Kathy Sanders (KathyJ.Sanders@ky.gov) or Julie Miracle (Julie.Miracle@ky.gov) or call **(502) 564-4478**

REMINDER: HEPATITIS C Reporting:

Hepatitis C: Perinatal and Children Aged Five Years or Less

Health care providers should report, http://www.lrc.ky.gov/kar/902/002/020.htm

- all HCV-positive pregnant women;
- all infants born to HCV-positive women; and
- all HCV-positive infants and children aged 5 years old and younger seen in birthing hospitals, medical practices and clinics

Remember: Routine testing for HCV is not recommended for all pregnant women. Pregnant women with a known risk factor for HCV infection should be offered counseling and testing. Data from the CDC states that approximately 6 out of every 100 infants born to HCV infected woman become infected. The risk is greater, 2 to 3 times, if the woman is co-infected with HIV. There is currently no HCV treatment approved for pregnant women.

http://www.cdc.gov/std/treatment/2010/hepc.htm

Infant born to mothers with HCV

Infants born to HCV-positive mothers should be tested for HCV infection. Children born to HCV-positive mothers can be tested with the **HCV RNA tests at 2 months of age or older** (at a routine well-child visit), or **HCV antibody testing can be done at 18 months of age** (HCV antibody testing should be delayed until 18 months of age to avoid detecting maternal antibody). The Kentucky Department for Public Health recommends the use of quantitative HCV RNA tests at 2 months of age or older to assess whether HCV was transmitted to the infant from the HCV-positive mother.

http://www.cdc.gov/hepatitis/hcv/hcvfaq.htm

Complete and fax the reporting form at the end of this newsletter.

Fax forms to 502-696-3803

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EPID 394(Rev August 2014)

Kentucky Reportable Disease Form

Department for Public Health
Division of Epidemiology and Health Planning
275 East Main St., Mailstop HS2E-A
Frankfort, KY 40621-0001

Hepatitis Infection in Pregnant Women or Child (under the age of five)
Fax Form to 502-696-3803

DEMOGRAPHIC DATA

Patient's Last Name	First	M.I.	Date of Birth	Age	Gender ☐ M ☐ F ☐ Unk

Address	City	State	Zip	County of Residence

Phone Number	Patient ID Number	Ethnic Origin ☐ His. ☐ Non-His.	Race ☐W ☐B ☐A/PI ☐Am.Ind. ☐Other

DISEASE INFORMATION

Describe Clinical Symptoms:	Date of Onset: / /	Jaundice: ☐Yes ☐No	Date of Diagnosis: / /

Is Patient Pregnant? ☐Yes ☐No If yes, # wks_____	Expected Date of Delivery: / /	Name of Hospital for Delivery:

Physician Provider Name: Address: Phone:		

LABORATORY INFORMATION

Hepatitis Markers	Results	Date of test	Viral Load *if applicable	Name of Laboratory
HBsAg	☐ Pos ☐ Neg	/ /		
IgM anti-HBc	☐ Pos ☐ Neg	/ /		
HBeAg	☐ Pos ☐ Neg	/ /		
IgM anti-HAV	☐ Pos ☐ Neg	/ /		
HCV Antibody	☐ Pos ☐ Neg	/ /		
HCV RNA Confirmation	☐ Pos ☐ Neg	/ /		

SERUM AMINOTRANSFERASE LEVELS

Patient	Reference	Date of test	Name of Laboratory
AST (SGOT) U/L	U/L	/ /	
ALT (SGPT) U/L	U/L	/ /	

Mother: Hepatitis Risk Factors
☐IDU ☐Multiple Sexual Partners ☐Tattoos ☐STD
☐HIV ☐Foreign Born/ Country _____
☐Exposure to known HBV/HCV Pos contact

Child: Hepatitis Risk Factors
☐Mother HBV Pos ☐Household member exposure HBV Pos
☐ Mother HCV Pos ☐Household member exposure HCV Pos
☐Foreign Born / Country_____

Mother: Hepatitis A vaccination history: ☐Yes ☐No ☐Refused Dates Given: / /
Hepatitis B Vaccination history: ☐Yes ☐No ☐Refused
If yes, how many doses ☐1 ☐2 ☐3 Year completed: / /
Child: Hepatitis A vaccination history: ☐Yes ☐No ☐Refused Dates Given: / /
Hepatitis B Vaccination history: ☐Yes ☐No ☐Refused Dates Given: / /
Was PEP Infant of Positive HBV mother given at birth? ☐Yes ☐No

Kentucky UNBRIDLED SPIRIT