

HEPATITIS B VACCINATION CONSENT FORM

I understand the benefits and risks of hepatitis B vaccination. I understand that I must receive at least 3 intramuscular doses of vaccine in the arm over a 6-month period to confer immunity. However, as with all medical treatment, there is no guarantee that I will become immune or that I will not experience an adverse side effect from the vaccine. I do understand that anyone with a known **allergy to yeast** should not accept this vaccine.

Hepatitis B vaccine will be made available at no charge to employees having occupational blood exposure.

I have had an opportunity to ask questions, and all my questions have been answered to my satisfaction. I believe that I have adequate knowledge upon which to base an informed consent.

I understand that participation is voluntary and my consent or refusal of vaccination does not waive any rights under my employment contracts. In addition, I can withdraw from the vaccination regimen at anytime.

I desire that my employer provide the required three (3) doses of Hepatitis B vaccine.

_____	_____
Print Name	Last 4 digits of Social Security #
_____	_____
Date	Signature

HEPATITIS B VACCINATION DECLINATION FORM

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

_____	_____
Print Name	Last 4 digits of Social Security #
_____	_____
Date	Signature

If applicable, please fill out the following information:

I have received the **Hepatitis B** vaccination on: _____, _____, _____.

_____	_____
Print Name	Last 4 digits of Social Security #
_____	_____
Date	Signature

Please return this completed form indicating whether you do (Consent) or do not (Declination) want the HBV vaccination to _____ at the _____ Office.