

HEPATITIS B IMMUNIZATION CONSENT/WAIVER FORM

By law, the Hepatitis B vaccine series will be made available to employees within 10 days of initial assignment to a position presenting occupational exposure and completion of required training unless the employee has previously received the complete Hepatitis B series, antibody testing reveals the employee is immune, or the vaccine is contraindicated for medical reasons.

Employee Name: _____

Position: _____ Site: _____

On _____ I ☐ attended a blood borne pathogen education and training class, or ☐ viewed a blood borne pathogen education webinar.

I understand that as part of my job, I may become exposed to blood or other potentially infectious items or materials that put me at risk for acquiring the Hepatitis B virus (HBV). Therefore, at no charge to myself, I have been offered the Hepatitis B vaccine, which is intended to render me immune to the HBV. At least three separate intramuscular injections are necessary to produce the desired immunity (sometimes additional injections are necessary to reach immunity), and all three doses are necessary in order for the vaccine to be effective. After the initial dose is given, repeat doses are given one month and six months later. There is a strong likelihood the vaccine will be successful if I receive all three doses, but there is a potential that even when administered properly the vaccine will not result in the desired immunity, such that there is a chance I may become infected with HBV even if I complete the full series.

All medicines may cause side effects, but most recipients of the vaccine have few or no side effects. The most commonly reported side effects include diarrhea, dizziness, fatigue, a general feeling of discomfort, headache, irritability, loss of appetite, mild fever or sore throat, nausea, pain, swelling, or redness at the injection site, runny nose, tiredness, weakness. In rare cases, more severe side effects may occur, including rash, hives, itching, difficulty breathing, tightness in the chest, swelling of the mouth, face, lips, or tongue, unusual hoarseness, fainting, fast or irregular heartbeat, red, swollen, blistered, or peeling skin, severe or persistent dizziness, unusual bruising or bleeding. In case of such reactions, seek immediate medical care or attention.

If the vaccine does not lead to the desired immunity (because I do not complete the three-dose series, or I choose not to receive supplemental injections if the first series does not develop immunity), or if I choose not to receive the vaccine at this time, I understand that I will need post-exposure treatment if I have a direct contact with blood, other body fluids, or other actually or potentially infected items, in order to address potential exposure concerns.

_____ I have read and understand the above information and wish to receive the hepatitis B vaccine series (three doses). I have no known sensitivity to yeast and I am unaware of any reason why the vaccine may cause me harm or lead to an adverse reaction.

_____ I have read and understand the information above. 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.

Date: _____

Signature: _____

HEPATITIS-B VACCINATION RECORD

1st Dose:

2nd Dose:

3rd Dose: