Hepatitis B Vaccination

(Please Print Information Here)

Name (first, last): _____

Department Name: _____ ☐ Volunteer ☐ Employee ☐ Student

Employee ID #: _____ Date of Birth: _____

Administration of Vaccine

Contraindications:

☐ **Yes** ☐ **No** Severe or life-threatening allergic reactions after a dose of Hepatitis B vaccine?

☐ **Yes** ☐ **No** Are you currently, moderately or severely ill?

☐ Yes, I have received the VIS form dated (**10/15/2021**) and have reviewed the information about the risks and benefits of the Hepatitis B vaccine and consent to receiving the Hepatitis B vaccine.

Date (Reviewed VIS): _____ Patient/Employee Signature: _____

If the above patient/employee is under the age of 18, they must be accompanied by a parent/guardian.

Parent/Guardian Signature: _____

Dose 1 Date of Admin: _____ Time: _____ Site: ☐ Left Upper Arm ☐ Right Upper Arm **(sticker):**

Manufacturer: _____ Lot #: _____ Exp. Date: _____

Administered/Reviewed By (include full name and title): _____

Dose 2 Date of Admin: _____ Time: _____ Site: ☐ Left Upper Arm ☐ Right Upper Arm **(sticker):**

Manufacturer: _____ Lot #: _____ Exp. Date: _____

Administered/Reviewed By (include full name and title): _____

Dose 3 Date of Admin: _____ Time: _____ Site: ☐ Left Upper Arm ☐ Right Upper Arm **(sticker):**

Manufacturer: _____ Lot #: _____ Exp. Date: _____

Administered/Reviewed By (include full name and title): _____

Waiver of Vaccine Only

I release Blessing Hospital from responsibility for ill effects which may result from my failure to comply with the policy. I am aware if I am exposed to Hepatitis B and have not provided proof of immunity or appropriate vaccination status I may at risk of acquiring Hepatitis B Virus (HBV). I am aware if I am exposed to the Hepatitis B in the future and want to be vaccinated with Hepatitis B vaccine I can.

Date: _____ Patient Signature: _____

Date: _____ Witness Signature: _____

BLESSING HEALTH