



HOWARD COUNTY  
GENERAL HOSPITAL

JOHNS HOPKINS MEDICINE  
OCCUPATIONAL HEALTH

**HEPATITIS B VACCINE CONSENT / DECLINATION FORM**

You are being given the Hepatitis B vaccine because you have a negative or low titer. The Hepatitis B vaccine can prevent the hepatitis B virus (HBV). HBV is a serious disease that can cause short-term (acute) illness and/or long-term (chronic) illness. Each year 80,000 people become infected with HBV. You will need to get 3 injections, the first now, second in one month and the third in six months. The most common side effects from this vaccine are soreness at the site of injection and mild to moderate fever. Please return or contact Occupational Health at ext. 7838 immediately if you experience any problems.

**You should not receive the vaccine if:**

- You have ever had a life-threatening allergic reaction to baker's yeast (the kind used for making bread), or to a previous dose of the Hepatitis B vaccine.
- You are moderately or severely ill.

**You should check with your primary caregiver if:**

- You are pregnant.

**Female Employees only - must be signed before each dose of the Hepatitis B vaccine.**

I am absolutely sure I am not pregnant.

Dose#1: Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dose#2: Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dose#3: Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Booster: Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Acceptance of the Vaccination** - I have read the information about the Hepatitis B vaccine. I understand the benefits and risk of the vaccine. I have had ample opportunity to ask questions and have them answered to my satisfaction regarding the disease, vaccine, and the possible risks and benefits. I further understand that Howard County General Hospital and it's' employees make no guarantee as to the effectiveness of the vaccine or the likelihood or severity of the occurrence of any of the risks from the vaccine.

I request the vaccine be given to me, and I have been given the Vaccine Information Statement dated 07/18/07.

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Employee's Name (Printed)

\_\_\_\_\_  
Date

|                  | Dose #1      |               | Dose #2      |               | Dose #3      |               | Booster      |               |
|------------------|--------------|---------------|--------------|---------------|--------------|---------------|--------------|---------------|
| Date of Dose     |              |               |              |               |              |               |              |               |
| Lot #            |              |               |              |               |              |               |              |               |
| Exp. Date        |              |               |              |               |              |               |              |               |
| Site: Circle One | Left Deltoid | Right Deltoid | Left Deltoid | Right Deltoid | Left Deltoid | Right Deltoid | Left Deltoid | Right Deltoid |
| Administered by: |              |               |              |               |              |               |              |               |

**Declination of the Vaccine:**

I decline the vaccine. Reason - please check:

- \_\_\_ previously had the Hepatitis B series
- \_\_\_ antibody testing has revealed I am immune to Hepatitis B.
- \_\_\_ other: please explain: \_\_\_\_\_

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 the Hepatitis B vaccine. However, I wish to decline the Hepatitis B vaccine 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 the Hepatitis B vaccine, I can receive the vaccine per Howard County General Hospital policy at any time.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

Phone #: \_\_\_\_\_

\_\_\_\_\_  
Witnessed by - Occupational Health Nurse Signature

\_\_\_\_\_  
Date



HOWARD COUNTY  
GENERAL HOSPITAL

JOHNS HOPKINS MEDICINE  
OCCUPATIONAL HEALTH  
5755 Cedar Lane  
Columbia, Md. 21044  
410-740-7838

HEPATITIS B VACCINE  
Questionnaire

Please complete the following questionnaire only if you are accepting the vaccine.

|   | <u>Yes</u> | <u>No</u> | <u>Not<br/>Applicable</u> |
|---|------------|-----------|---------------------------|
| 1. Are you allergic to products which contain yeast or alum?  | ___        | ___       | _____                     |
| 2. Have you ever developed a rash, itching or other symptoms after any injection?                     | ___        | ___       | _____                     |
| 3. Do you currently have a cold/fever or other active infection?                                      | ___        | ___       | _____                     |
| 4. Do you have a history of any heart problems, breathing difficulties, or lung problems?             | ___        | ___       | _____                     |
| 5. Are you currently pregnant or planning to have children in the near future?                        | ___        | ___       | _____                     |
| 6. Are you currently breast feeding and/or giving your breast milk to your child?                     | ___        | ___       | _____                     |
| 7. Do you have a history of immunodeficiency problems or are you receiving immunosuppressive therapy? | ___        | ___       | _____                     |

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date Signed