Code No. 403.3E1

**HEPATITIS B VACCINE INFORMATION AND RECORD**

The Disease

Hepatitis B is a viral infection caused by the Hepatitis B virus (HBV) which causes death in 1-2% of those infected. Most people with HBV recover completely, but approximately 5-10% become chronic carriers of the virus. Most of these people have no symptoms, but can continue to transmit the disease to others. Some may develop chronic active hepatitis and cirrhosis. HBV may be a causative factor in the development of liver cancer. Immunization against HBV can prevent acute hepatitis and its complications.

The Vaccine

The HBV vaccine is produced from yeast cells. It has been extensively tested for safety and effectiveness in large scale clinical trials.

Approximately 90 percent of healthy people who receive two doses of the vaccine and a third dose as a booster achieve high levels of surface antibody (anti-HBs) and protection against the virus. The HBV vaccine is recommended for workers with potential for contact with blood or body fluids. Full immunization requires three doses of the vaccine over a six-month period, although some persons may not develop immunity even after three doses.

There is no evidence that the vaccine has ever caused Hepatitis B. However, persons who have been infected with HBV prior to receiving the vaccine may go on to develop clinical hepatitis in spite of immunization.

Dosage and Administration

The vaccine is given in three intramuscular doses in the deltoid muscle. Two initial doses are given one month apart and the third dose is given six months after the first.

Possible Vaccine Side Effects

The incidence of side effects is very low. No serious side effects have been reported with the vaccine. Ten to 20 percent of persons experience tenderness and redness at the site of injection and low grade fever. Rash, nausea, joint pain, and mild fatigue have also been reported. The possibility exists that other side effects may be identified with more extensive use.

Page 1 of 5

Code 403.3E1

Bill to:

**HEPATITIS B IMMUNIZATION CONSENT OR REFUSAL**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Employee's Name (please print)** | | | |  |  |  | **Social Security #:** | |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **Birth date:** | |  | **Telephone #: work:** | | |  | **Doctor:** |  |  |  |
|  |  |  |  | **home:** | |  |  |  |  |  |
| **Allergies:** | |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |

I have read the information about Hepatitis B and the Hepatitis B vaccine (Code No. 403.3E1). I have had an opportunity to ask questions of a qualified nurse or physician and understand the benefits and risks of Hepatitis B vaccination. I understand that I must have 3 doses of the vaccine to obtain immunity. However, as with all medical treatment, there is no guarantee that I will become immune or that I will not experience side effects from the vaccine.

**CONSENT TO HEPATITIS B VACCINATION**

**I understand that records of the immunizations administered today will be sent to my physician**

Signature of person to receive vaccine Date signed

Witness Date signed

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date Vaccinated** | | | **Lot No.** | | | **Site** | | **Administered By** | | |
| **1.** |  |  |  |  |  |  |  |  |  |  |
| **2.** |  |  |  |  |  |  |  |  |  |  |
| **3.** |  |  |  |  |  |  |  |  |  |  |

**REFUSAL OF HEPATITIS B VACCINATION**

After reviewing and discussing the information on Hepatitis B and the Hepatitis B vaccine and after careful consideration of the risks to my health, I hereby refuse the Hepatitis B vaccination. I am aware that I may change this decision by signing the above consent at a later date.

Signature of Employee Date signed

Signature of Witness Date signed

Page 2 of 5

Code No. 403.3E1

**HEPATITIS B VACCINE INFORMATION AND RECORD**

***RELEASE FOR HEPATITIS B MEDICAL INFORMATION***

I hereby authorize \_\_\_\_\_\_\_   (individual or organization holding Hepatitis B records and address) to release to the Estherville Lincoln Central Community School District, my Hepatitis B vaccination records for required employee records.

I hereby authorize release of my Hepatitis B status to a health care provider, in the event of an exposure incident.

  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Employee Date

  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness Date

Page 3 of 5

Code No. 403.3E1

**HEPATITIS B VACCINE INFORMATION AND RECORD**

***CONFIDENTIAL RECORD***

  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Name (last, first, middle) Social Security No.

Job Title:

Hepatitis B Vaccination Date Lot Number Site Administered by

1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Hepatitis B status information:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Post-exposure incident: (Date, time, circumstances, route under which exposure occurred)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Identification and documentation of source individual:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Source blood testing consent:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of employee's duties as related to the exposure incident:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Copy of information provided to health care professional evaluating an employee after an exposure incident:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page 4 of 5

Code No. 403.3E1

Attach a copy of all results of examinations, medical testing, follow-up procedures, and health care professional's written opinion.

Training Record: (date, time, instructor, location of training summary)

Page 5 of 5