CENTER FOR OCCUPATIONAL HEALTH & WELLNESS
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HEPATITIS-B VACCINATION FORM

LAST NAME_____ **FIRST** _____ **M.I.** _____

DOB (MM/DD/YY): _____ **SEX:** ☐ **M** / ☐ **F** *(Check One)*

Hepatitis B Vaccination: Consent Form

I have read the information about hepatitis B and the hepatitis B vaccine. I have had the opportunity to ask questions and understand the benefits and risks of hepatitis B immunization. I agree to receive the three doses required for the optimum immune response. However, as with all medical treatment, I understand there is no guarantee that I will become immune or that I will not experience adverse side effects from the vaccine.

Hepatitis B Vaccination Record

DOSE #:	Date Given:	Given By:	Site Given:	
# 1: Primary Dose				
	Manufacturer:	NDC #:	Lot #:	Exp. Date:
# 2: 1 Month after primary dose	Date Given:	Given By:	Site Given:	
	Manufacturer:	NDC #:	Lot #:	Exp. Date:
# 3: 6 Months after primary dose	Date Given:	Given By:	Site Given:	
	Manufacturer:	NDC #:	Lot #:	Exp. Date: