

# St. Clair County Community Mental Health

## Hepatitis B Vaccine Consent/Waiver

Name (Print): \_\_\_\_\_

Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

### A. Consent for Hepatitis B Vaccine

I, \_\_\_\_\_ consent to be immunized against Hepatitis B Virus, via Hepatitis B vaccine.  
(Print Name)

I acknowledge that:

1. I have been informed that I am at risk of acquiring Hepatitis B Virus because of the nature of my professional responsibilities.
2. I have read the information sheet that lists the indications, benefits, and presently known side effects of Hepatitis B vaccine, have had an opportunity to ask questions, and have had them answered to my satisfaction.
3. I must receive three (3) doses of vaccine over a period of six (6) months to confer optimal immunity.
4. I understand that, as with all medical treatment, there is no guarantee that I will become immune or that I will not experience an adverse reaction to the vaccine.
  - In the event that I experience any adverse side effects or do not become immune from the vaccine I hereby hold St. Clair County Community Mental Health Authority harmless from any and all liability to the extent permitted under the law.
5. In the event that my employment is terminated from St. Clair County Community Mental Health, prior to completing Hepatitis B vaccine, I understand that if I continue the vaccine series, it would then become my responsibility to complete on my own initiative and at my own expense.

\*If female, are you currently pregnant or breast feeding? Yes \_\_\_\_\_ No \_\_\_\_\_

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

\_\_\_\_\_  
Program

\_\_\_\_\_  
Date

Hepatitis Vaccine Record (Dates) 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

### B. Previous Immunization with Hepatitis B Vaccine

I, \_\_\_\_\_, have previously completed a three-dose series of Hepatitis B vaccine  
(Print Name)

at \_\_\_\_\_ in \_\_\_\_\_.  
(Print Location) (Print Year)

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

\_\_\_\_\_  
Program

\_\_\_\_\_  
Date

### C. Refusal to Receive Hepatitis B Vaccine

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 my 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.

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

\_\_\_\_\_  
Program

\_\_\_\_\_  
Date

\_\_\_\_\_  
Hepatitis B Specialist Signature

\_\_\_\_\_  
Date