



HEPATITIS B IMMUNIZATION CONSENT/WAIVER

Employee's name _____ SID number _____

Job title _____ Supervisor _____

I have received training regarding Hepatitis B virus: YES No Date of training _____

Please read each of the following items carefully:

1. I understand that I will need a series of **three** injections of Hepatitis B vaccine in order to be protected from Hepatitis B virus infection. The vaccine is 80-90% efficient in preventing hepatitis B. Responsiveness is age dependent, with children showing a more active response to the vaccination than adults.
2. I understand that I should consult with a health care provider before receiving the vaccine if I can be described in any one of the following categories: pregnant women; nursing mothers; persons with severe heart or lung problems or a documented immune deficiency; persons who are allergic to yeast; persons with a bleeding disorder that prevents them from receiving an intramuscular shot; persons with a fever or serious, active infection; or who have received another type of vaccine in the past 14 days.
3. **Risks and possible side effects:** Some people will have tenderness at the injection site for a few days. Some will have fevers, chills, headaches, muscular aches or a rash within the first 48 hours. Although no serious adverse reactions attributable to the hepatitis B vaccination have been reported during the course of clinical trials, there is always the possibility that a broader use of the vaccine could reveal adverse reactions not observed in the clinical testing. As with the administration of any vaccine or drug, there is always the possibility of more severe effects (and, in rare instances, even death). If a severe reaction occurs (or lasts over 48 hrs.), it is recommended that you see a health care provider.

Please read each of the following two sections carefully, **sign only one** (the section which reflects your decision at this time), and submit the signed form to the trainer prior to leaving the training. The signed form will be retained in the CCS Environmental Health and Safety office.

SECTION I: CONSENT TO RECEIVE THE HEPATITIS B IMMUNIZATION SERIES:

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 read and I understand the information on this form and I wish to be vaccinated with Hepatitis B vaccine, a series of three doses of vaccine, at no charge to myself. **I have no known sensitivity to yeast.**

Signature _____ Date _____

SECTION II: WAIVER OF THE HEPATITIS B IMMUNIZATION SERIES:

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 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, while employed by the Community Colleges of Spokane, and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me. I have read and I understand the information on this form and I **DO NOT** wish to be vaccinated with Hepatitis B vaccine, a series of three doses of vaccine, at this time.

Signature _____ Date _____

I have already completed the 3-shot immunization series.



HEPATITIS B VACCINATION AUTHORIZATION

Employee Instructions

The Hepatitis B Vaccination is administered in a series of three injections – at zero month, one month later, and six months from date of first vaccination. All three injections are required to effectively provide immunization. To receive the Hepatitis B vaccination series, you will need to complete this form (with proper signatures) and take it to the immunization clinic at the time of each series. The clinic will provide a receipt of the statement of services to the Community Colleges of Spokane Environmental Health and Safety Department, 533-8686.

Immunizations given at:

Occupational Medicine Associates
323 E. Second Ave
Spokane, WA 99202

Hours:

Monday - Friday
7:30 AM – 4:45 PM
509-455-5555

The Clinic recommends calling for an appointment. Please call 455-5555 to confirm a date and time.

Employee name (Please Print): _____

Employee Signature: _____ Date: _____

Occupational Medicine Associates

The above-named CCS employee is hereby authorized to receive the Hepatitis B vaccination. The immunization costs associated with the administration of the vaccine will be paid by the Community Colleges of Spokane upon receipt of the statement of services. The invoice should be submitted to:

Community Colleges of Spokane
Purchasing Department MS 1007
PO Box 6000
Spokane, WA 99217-6000

Attention Supervisor or Authorized Designee:

I authorize the above-named individual to receive the Hepatitis B vaccination series.

The cost of this vaccination series will be charged to P-Card (last 4 digits) budget number(s):

Supervisor or authorized designee (Please Print): _____

Supervisor or authorized designee (Signature): _____

Date: _____

Phone number: _____