Page County Public Health
1208 W. Nishna Rd., Suite B
712-246-2332

LATEX
ALLERGY?
___Yes___No
____

HEPATITIS B VACCINATION CONSENT FORM

Date	Dose 1	Dose 2	Dose 3
Manufacturer			
Lot #			
Site of Injection			
Administrator			
Payment	CK/Cash $ Date:	CK/Cash $ Date:	CK/Cash $ Date:

Full Name: ______________________________ **Age:** __________

Birth date: ____________ **Soc Sec:** ____________ **Phone:** ____________

Address: ____

City: ______________ **Zip Code:** __________ **County:** __________

Physician: ________________________ **City:** ______________

Allergies: ____

I have been given a copy and have read or have had explained to me the information on Hepatitis B, Hepatitis B Vaccine, and Hepatitis B Immune Globulin (Hepatitis B 7/18/07). I have had a chance to ask questions which were answered to my satisfaction. **I understand that I must have 3 doses of the vaccine; 1st one now, 2nd in 1 month, and the 3rd in 6 months from the 1st dose.** I believe I understand the benefits and the risks of hepatitis B immune globulin and the hepatitis B vaccine.

Signature ______________________________ **Date** ______________

Signature ______________________________ **Date** ______________

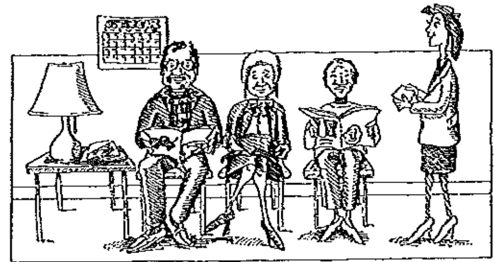
Signature ______________________________ **Date** ______________

Revised 9/14/11

OFFICE USE: ____ **Private Pay** ____ **Business to Bill:** ______________________

Patient name: ______________________ Date of birth: ___/___/___ (mo.) (day) (yr.)

Screening Questionnaire for Adult Immunization



For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, or any vaccine?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☐	☐
5. Do you have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	☐	☐	☐
7. Have you had a seizure, brain, or other nervous system problem?	☐	☐	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

Form completed by: ______________________ Date: __________

Form reviewed by: ______________________ Date: __________

Did you bring your immunization record card with you? **yes** ☐ **no** ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

Technical content reviewed by the Centers for Disease Control and Prevention, April 2009.

www.immunize.org/catg.d/p4065.pdf • Item#P4065 (4/09)