|  |
| --- |
| **Hepatitis B Immunization Consent/Refusal Form** |
| ***Please check one*** |
| **Yes, I want to receive the Hepatitis B vaccine:** |
| I read the information given to me about Hepatitis B virus and Hepatitis B vaccine and I had the  opportunity to ask questions. My questions were answered.  I want to participate in the vaccination program. I understand this includes three injections at prescribed intervals over a six month period. I understand that there is no guarantee that I will become immune to Hepatitis B. I understand that I might experience an adverse side effect as the result of the vaccination.  Date Given Lot # Administered By Next Date Due  1st Dose:  2nd Dose:  3rd Dose: |
| **No, I don’t want to receive the Hepatitis B Vaccine:** |
| I understand that due to my occupational exposure to blood or other potentially infectious material, I may be at risk of acquiring Hepatitis B Virus (HBV). I was given the opportunity to be vaccinated with Hepatitis B vaccine at no charge to me. However, I **decline** Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at an increased risk of acquiring Hepatitis B, a serious disease.  If in the future, I want to be vaccinated with the Hepatitis B vaccine, I understand that I can receive the vaccine series at no charge to me. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Employee Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_  Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| PRIVACY ACT INFORMATION  Agency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  The collection and use of this information are consistent with the provisions of 5 U.S.C. 552a (Privacy Act of 1974). This information is sensitive and protected by the Privacy Act. It is only available to staff on a need to know basis. Electronic material must be password protected and must not be used except in accordance with routine uses identified in OPM/GOVT-10, Employee Medical File System Records. Paper records must be similarly used and protected in a locked file or room that is available only to staff who have a need to know this information and in accordance with OPM/TGOVT |