



## Occupational Medicine Forms

### HEPATITIS B VACCINE RELEASE FORM

EMPLOYER INFORMATION	
Company Name: _____	Fax #: _____

Form of ID:  DL  Employee Badge  Other:

EMPLOYEE INFORMATION		
FULL NAME: _____		DOB: _____
<b>YES</b>	<b>NO</b>	<b>PLEASE ANSWER ALL QUESTIONS BELOW BY CHECKING THE APPROPRIATE YES OR NO BOX.</b>
		Are you pregnant or do you think you might be?
		Do you have a fever, acute respiratory or other active infections or illnesses?
		Have you had a Hepatitis B shot before?
		Are you allergic to any substances, foods or medications? If so, please list: _____
		Have you had another type of vaccine within the past 14 days?
		Do you have any current medical problems that you are under the care of a physician for? If so, please list: _____

Please initial and sign below:

\_\_\_\_ I have been given a copy and have read or have had explained to me, the information in the "Vaccine Information Statement(s)" for the disease(s) and vaccine(s) above. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccines requested and ask that the vaccine(s) indicated on this form be given to me.

\_\_\_\_ I agree to allow the health care provider giving vaccinations to release information about all vaccinations given to me to the person / employer indicated on this form and to other entities in order to avoid receiving unnecessary vaccinations and to provide information about what immunizations have been received. I understand that I am not required to agree to the release of this information in order to receive the vaccinations I request.

\_\_\_\_ I certify that the following information is correct to the best of my knowledge.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR INTERNAL USE ONLY**

Manufacturer Lot # _____	Injection Site: _____
Staff Signature: _____	Date Vaccinated: _____
Manufacturer Lot # _____	Injection Site: _____
Staff Signature: _____	Date Vaccinated: _____
Manufacturer Lot # _____	Injection Site: _____
Staff Signature: _____	Date Vaccinated: _____