

Employee Name: \_\_\_\_\_  
Department/Unit: \_\_\_\_\_  
Home Campus: \_\_\_\_\_  
Date: \_\_\_\_\_ D.O.B.: \_\_\_\_\_



## DECLINATION FORM FOR HEPATITIS B VACCINE

**PLEASE CHECK ONE OF THE 3 BOXES BELOW.**

- I decline vaccination with the Hepatitis B vaccine at this time, because my job category does not involve direct patient care and therefore, I am at low risk of acquiring Hepatitis B infection while performing my job duties.
- I decline vaccination with Hepatitis B vaccine because I have been vaccinated with a full series of 3 Hepatitis B vaccines in \_\_\_\_\_ (approx. year(s)).
- I have been tested for the antibodies after I completed the Hepatitis B vaccine series and the test showed:
- Immunity    No immunity    Unknown  
*(Attach documentation, if possible)*
- I have never had antibody testing done to check my immune response.
- 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, but I decline Hepatitis B vaccination at this time.
- Due to concerns of side effects.
- Due to allergy.
- I am/may be pregnant, if so, I will check with my provider regarding receiving the vaccine during my pregnancy.
- I am immunocompromised due to medications or other conditions.
- Other: \_\_\_\_\_

If I have not received the vaccine series, I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. I have been given a Vaccine Information Sheet to review on the Hepatitis B vaccine and I have been given additional resource information in the form of the CDC website and still chose to not be vaccinated. I know I can receive the vaccine(s), at any time, free of charge, in the Employee Health Department, even after I sign this declination form.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**Return completed form to the Employee Health Office ASAP**



Employee Name: \_\_\_\_\_  
 Department / Unit: \_\_\_\_\_  
 Home Campus: \_\_\_\_\_  
 Date: \_\_\_\_\_ D.O.B.: \_\_\_\_\_



## HEPATITIS B VACCINE CONSENT

Do you have any allergies to any foods (including yeast), medications or latex products?  Yes  No

If YES, please list: \_\_\_\_\_

(If yes, do not give vaccine until cleared by EH / Occumed)

- I have read the Hepatitis B Vaccine Information Statement (VIS), dated \_\_\_\_\_ provided to me.
- I have had the opportunity to ask questions, and I understand the benefits and risks of the Hepatitis B vaccine.
- I understand that I must complete three (3) doses of vaccine to develop antibodies. However, as with all medical treatment, there is no guarantee that I will become immune or that I will not experience side effects from the vaccine.
- I request that the Hepatitis B vaccine be given to me or to the person named above, of whom I am the parent/guardian.

\_\_\_\_\_  
 EMPLOYEE SIGNATURE / PARENT / GUARDIAN SIGNATURE,  
 IF UNDER 18 YEARS OF AGE / RELATIONSHIP

\_\_\_\_\_  
 DATE

\_\_\_\_\_  
 TIME

### FIRST SERIES

Dose	Date Immunized	Manufacturer Lot # / Exp. Date	Dose	Route	Site	Administered by: Signature
#1			1.0 ml	IM	Left / Right Arm	
#2			1.0 ml	IM	Left / Right Arm	
#3			1.0 ml	IM	Left / Right Arm	

Hepatitis B Surface **Antibody** Test Result:

Immune, vaccination complete

Date: \_\_\_\_\_

Non-immune, see below for further vaccination

Result: \_\_\_\_\_

Non-immune, see reverse for declination of further vaccination

Hepatitis B Surface **Antigen** Test Result:

Date: \_\_\_\_\_

Result:  Negative  Positive

### SECOND SERIES

Dose	Date Immunized	Manufacturer Lot # / Exp. Date	Dose	Route	Site	Administered by: Signature
#4			1.0 ml	IM	Left / Right Arm	
#5			1.0 ml	IM	Left / Right Arm	
#6			1.0 ml	IM	Left / Right Arm	

Hepatitis B Surface **Antibody** Test Result:

Immune

Date: \_\_\_\_\_

Non-immune, 2nd Series – Non-responder

Result: \_\_\_\_\_

