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- Bethesda Care Butler County Phone: 513-874-3990 Fax: 513-860-5071
- Bethesda Care Eastgate Phone: 513-752-3695 Fax: 513-752-3039
- Bethesda Care Norwood Phone: 513-731-3399 Fax: 513-731-2882
- Bethesda Care Queensgate Phone: 513-241-4135 Fax: 513-241-6510
- Bethesda Care Sharonville Phone: 513-563-1505 Fax: 513-769-4776
- Good Samaritan Phone: 513-862-2875 Fax: 513-862-2860

**Occupational
Medicine
Services**

HEPATITIS B IMMUNIZATION QUESTIONNAIRE

PATIENT NAME: _____ DATE: _____

	YES	NO
Do you have any allergies to any medications?		
Are you allergic to yeast, formaldehyde, bread mold or thimerosal (a mercury derivative)?		
Are you pregnant or suspect that you are?		
Are you nursing an infant?		
Do you have any known heart or lung problems?		
Are you on any chemotherapeutic agents?		
Are you receiving hemodialysis treatment?		
Are you currently on any medications?		
Are you currently under a doctor's care?		
Have you had any of the following symptoms in the past seven (7) days?		
a. Fever		
b. Cold symptoms		
c. Sore throat or difficulty swallowing		
d. Stomach pain		
e. Diarrhea		
f. Vomiting		
g. Skin rash		
h. Pain or burning on urination		

If you answered yes to any of the above, please explain: _____

I verify that the information furnished is complete and true. I take full responsibility for any falsification of information provided.

Patient's Signature: _____



Bethesda TriHealth Good Samaritan

CONSENT FOR HEPATITIS B VACCINATION TRIHEALTH OCCUPATIONAL MEDICINE CENTERS

HEPATITIS B VACCINE CONSENT

I have received and read the _____ (date) VIS information concerning hepatitis B vaccine. I have had an opportunity to ask questions concerning this vaccine and they have been answered to my satisfaction. I understand the benefits and risks of hepatitis B vaccination.

I request that the vaccine be administered to me. I understand that I must receive a series of three doses. A blood test is strongly recommended a minimum of four (4) weeks after the third dose to determine immunity.

I agree to comply to the following schedule:

- ◆ Initial vaccination
- ◆ The second dose one month after the initial dose
- ◆ The third dose five months after the second dose

It is my responsibility to come to the TriHealth Occupational Medicine Center at the recommended intervals for vaccines and follow-up blood test. As with all medical treatment, there is no guarantee that I will become immune or that I will not experience any adverse side effects from the vaccine.

Name (print):	Company name:
Signature:	Date:
Witness:	Date:

DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B (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 and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to myself.

Signature:	Date:
Witness:	Date:

VACCINATION ADMINISTERED

DOSES	DATE	MANUFACTURER LOT#	EXP. DATE	SITE	TEMP	GIVEN BY
1 st				1 ml IM		
2 nd				1 ml IM		
3 rd				1 ml IM		
Titre		Results:				

Adverse reaction after 15 minute wait: Yes ___ No ___