# EMPLOYEE CONSENT TO HEPATITIS B VACCINE

On _____ (Date), I _____ (Name) received information concerning the risk of occupational exposure to blood or other potentially infectious material in the position of _____ (Job Title), which has been determined as job classification exposure Category _____ (I or II). I have received a copy of the Hepatitis B information packet which has been explained to me, and I understand this information.

I have been informed and understand (1) that Hepatitis B vaccination may reduce the potential risk of occupationally contracted viral hepatitis infection, and (2) the risks of the Hepatitis B vaccination which may include pain, itching, bruising at the injection site, sweating, weakness, chills, flushing and tingling and (3) to obtain adequate immunity to viral Hepatitis B, it will be necessary to receive all three vaccinations of the vaccine series which are administered one month and six months after the initial vaccination and (4) that the vaccination will be provided to me free of charge by _____ (Name of County). If at such future time the U.S. Public Health Service recommends a booster dose(s) of Hepatitis B vaccine, such booster dose(s) shall also be provided to me at no cost if I am employed by the County in a job classification that involves some risk of an occupational exposure to blood or other potentially infectious materials.

If I leave the employment of this County before the series is completed, it is my responsibility to contact my own medical provider to complete the vaccine series.

I hereby consent to the administration of the Hepatitis B vaccination and voluntarily acknowledge that:

I do not have an allergy to yeast.
I am not pregnant or nursing.
I am not planning to become pregnant within the next six months.
I have not had a fever, gastric symptoms, respiratory symptoms or other signs of illness in the last 48 hours.
I do have the following known allergies:
Food: _____
Drugs: _____
Other: _____

**YOU MAY WISH TO CONSULT WITH YOUR PHYSICIAN BEFORE TAKING THE VACCINE.**

_____ _____
(Employee Signature and Social Security Number) (Date)

_____ _____
(Witness) (Date)