

Hepatitis B Immunization Consent Form

The Hepatitis B vaccine is administered in two doses through a voluntary school based immunization program. Please read the attached Hepatitis B information and if further information is required, call 625-5971 or visit TBDHU.COM

Please complete and return this form to your child's school.

PLEASE COMPLETE AND RETURN THIS FORM TO YOUR CHILD'S SCHOOL.

Student's Last Name _____ First Name _____

Date of Birth (YY/MM/DD) _____ Age _____ Male Female

School _____ Grade _____

Parent/Guardian Contact Information (please print):

Name _____

Home () _____ Daytime Contact () _____

PLEASE CHECK ONE BOX ONLY AND SIGN BELOW:

Yes, please vaccinate my child with the Hepatitis B vaccine.

I have read or had explained to me the attached information about the vaccine, benefits, side effects and risks of immunization. I am satisfied with the answers to my questions. Unless cancelled, this request is valid for the time needed to give the vaccine.

No, I do not consent to have the Hepatitis B vaccine administered to my child.

X _____
Signature of parent/guardian/student Date

If any vaccine listed below has already been given, please provide the date(s).

Hepatitis B Dose #1 _____ Dose #2 _____ Dose #3 (if given) _____
Twinrix® Dose #1 _____ Dose #2 _____ Dose #3 (if given) _____

NURSE USE ONLY

Vaccine: Hepatitis B 1.0 mL IM

Dose #1

Date _____ Time _____ Deltoid LT RT Nurse Signature _____

Dose #2

Date _____ Time _____ Deltoid LT RT Nurse Signature _____