SUMNER Regional Medical Center
HIGHPOINT HEALTH SYSTEM

HEPATITIS B VACCINE CONSENT/REFUSAL FORM

VIS Date: 10/15/2021

Hepatitis B infection is caused by Hepatitis B virus which causes death in 1% to 2% of patients. Most people with Hepatitis B recover completely, but approximately 5% to 10% become chronic carriers of the virus. Most of these people have no symptoms, but can continue to transmit the disease to others. The health care provider is at increased risk in acquiring this infection.

Hepatitis B Vaccine (recombinant) is available and requires three injections for adequate immune response, although some persons may not develop immunity even after three doses. The duration of immunity is unknown at this time. The vaccine has been tested extensively for safety and efficacy in large scale clinical trials with human subjects.

Engerix-B is a noninfectious recombinant DNA hepatitis B vaccine. It contains purified surface antigen of the virus obtained by culturing a genetically engineered yeast cell which carries the surface antigen gene of the hepatitis B virus. The product contains no more than 5% yeast protein.

The vaccine side effects are very low. Tenderness and redness of the injection site and low grade fever may occur. Rash, nausea, joint pain and mild fatigue have also been reported. I should not take this vaccine if pregnant or nursing because effects at this time are unknown. I further understand that I should not take this vaccine if active infection is present or an allergy to the compound is known.

I have read the above statement about Hepatitis B and Hepatitis B vaccine. I have received a current Vaccine Information Statement (VIS), I understand the risks and benefits of Hepatitis B vaccination and have had the opportunity to ask questions. I understand I must have three doses of the vaccine to confer immunity. However, as with all medical treatment, there is no guarantee that I will become immune or that I will not experience adverse side effects from the vaccine.

______________________________	______________________________
I request the vaccine be given to me (Please Print Name)	I do not wish to participate in the program (Please Print Name)
______________________________ Signature of Associate	______________________________ Signature of Associate
______________________________ Department/Employer	______________________________ Date

Per this Job Description's OSHA category, the job duties do not require exposure to bloodborne pathogens.

______________________________ ______________________________
Nurses Signature Date

Certification of Vaccination

I certify the above-named individual was vaccinated against Hepatitis B on the following dates:

1st Inj Date: ________________ **Nurse:** ______________________________

Manufacturer/Lot#: ______________________ **Exp. Date:** __________ **Site:** ______

2nd Inj Date: ________________ **Nurse:** ______________________________

Manufacturer/Lot#: ______________________ **Exp. Date:** __________ **Site:** ______

3rd Inj Date: ________________ **Nurse:** ______________________________

Manufacturer/Lot#: ______________________ **Exp. Date:** __________ **Site:** ______