SUNY DOWNSATE Medical Center

University Hospital of Brooklyn
College of Medicine
School of Graduate Studies
College of Nursing
College of Health Related Professions

Student/Employee Health Service

HEPATITIS B CONSENT

I ______________________________ have read and understand the
(Print Name)

Statement about Hepatitis B vaccine. I have had an opportunity to ask questions and understand the
benefits and risks of Hepatitis B vaccination. I understand that I must have three (3) doses of 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 an adverse side effect from the vaccine. I request that it be given
to me.

(Signature of Person receiving Vaccine)

<table>
<thead>
<tr>
<th>DATE</th>
<th>DUE DATE VACCINATED</th>
<th>LOT #:EXP DATE</th>
<th>ADMINISTERED BY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose #1</td>
<td>___________________</td>
<td>________</td>
<td>___________________</td>
</tr>
<tr>
<td>Dose #2</td>
<td>___________________</td>
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<tr>
<td>Dose #3</td>
<td>___________________</td>
<td>________</td>
<td>___________________</td>
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<tr>
<td>Booster</td>
<td>___________________</td>
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</tbody>
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DECLINATION
TO HEPATITIS B VACCINE

I ______________________________ understand that due to my occupational exposure to blood
(Print Name)
or other potentially Infectious materials I may be at risk of acquiring Hepatitis B Virus (HBV) infection.
I have been given the opportunity to receive 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 me therefore I am declining it at this
time.

(Signature of Person declining Vaccine)

Or

I ______________________________ claim to have previously received
(Print Name)

Hepatitis B Vaccine from ____________________________
(Print Name Person/Facility/Date Vaccine Received)

State University of New York Downstate Medical Center

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