_____ Scanned in QS1 _____ QS1 Immunization Record _____ Faxed Dr/HD

Hepatitis B Vaccine Consent Form

Must be 20 years of age or older
Must remain in pharmacy for 10 minutes after injection

PERSONAL INFORMATION

[PLACE RX LABEL HERE]	PATIENT PHONE: ( ) -	
	DATE OF BIRTH: / /	AGE:
	☐ FEMALE ☐ MALE	
	COUNTY:	
	FAMILY DOCTOR:	
	MEDICARE/COMMERCIAL INSURANCE ID:	

SCREENING QUESTIONS

1.	Are you currently sick with a fever?	☐ Yes ☐ No
2.	Do you have a severe (life-threatening) allergy to **latex**, **yeast**, or any component (or part) of this vaccine, including soy peptone, dextrose, amino acids, mineral salts, formaldehyde, potassium aluminum sulfate, aluminum hydroxyphosphate sulfate, sodium chloride, disodium phosphate dihydrate, and sodium dihydrogen phosphate dihydrate?	☐ Yes ☐ No
3.	Have you ever had a severe (life-threatening) allergic reaction to a previous dose of any vaccine?	☐ Yes ☐ No
4.	Are you currently receiving dialysis?	☐ Yes ☐ No
5.	For women: Are you currently pregnant or breastfeeding?	☐ Yes ☐ No

Please remain in the pharmacy for 10 minutes following the vaccination. If you leave, you are doing so against medical advice.

I have read or have had explained to me the information in the Vaccine Information Statement about Hepatitis B vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of Hepatitis B vaccine and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request. I waive and release all claims I, or anyone claiming by or through me, now have or may hereafter acquire against Dr. James Schwieterman, MD, Schwieterman Pharmacies, and their respective directors, officers, employees, and agents for any damage or injuries if I, or the person named below for whom I am authorized to make this request, contact Hepatitis B, other diseases, or suffer any other adverse reactions following administration of this Hepatitis B vaccine. **I understand that I may be held responsible for charges that are not covered by my insurance. I understand that if I do not provide the proper insurance information I may also be held responsible for charges.** For Medicare Recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party that accepts assignment.

SIGNATURE OF PERSON TO RECEIVE VACCINE OR PERSON AUTHORIZED TO MAKE THE REQUEST (PARENT OR LEGAL GUARDIAN) **DATE**

-----FOR CLINIC/OFFICE USE ONLY-----

IMMUNIZER:	TITLE:	DATE OF IMMUNIZATION:	VIS DATE: 7/20/2016	SITE OF INJECTION: ☐ LA/IM ☐ RA/IM
VACCINE/MFG/DOSAGE: ☐ Engerix-B 20 mcg/GSK/1ml ☐ Recombivax HB 10 mcg/Merck/1ml		LOT #:		EXP DATE:
INSURANCE: ☐ Medicare ☐ Rx Coverage ☐ Major Med ☐ Cash ☐ ____________		STORE: ☐ CL ☐ CW ☐ MIN ☐ NB ☐ SM ☐ WP		

DOSE _____ OF 3 (Dose 2 is given 1 month after Dose 1 & Dose 3 is given 5 months after Dose 2)

Updated Aug 2018