82 Norwich-Westerly Road
North Stonington CT 06359

North Stonington Medical Walk-In Center, PC

Phone: (860)599-2469
Fax : (860)599-2830

Hepatitis B Vaccination Consent

Name:_____ Date of Birth_____

Street Address:_____

City:_____ State:_____ Zip:_____

Telephone:_____ SSN:_____

Have you ever received the Hepatitis B series? Yes / No
If yes, when?_____
Do you believe you have been exposed to Hepatitis B? Yes / No

Have you had an adverse reaction to Hepatitis B vaccine in the past? Yes / No

Do you have any severe allergies? Yes / No

If yes, please list:_____

Do you have a life-threatening allergy to baker's yeast? Yes / No

I have read, or had explained to me, the information sheet relating to the Hepatitis B Vaccine. I have been given the chance to ask questions and have been provided answers by this medical practice. I understand the benefits and risks of the vaccination as described in the information sheet provided.

I request the Hepatitis B vaccine series be given to me (or to the person for whom I am authorized to make this request). I understand that the initial vaccination is given in a series of three scheduled injections. I understand that the Hepatitis B booster is given as one injection as necessary (usually as a result of low immunity reported through lab blood test).

I authorize the release of any medical or other information necessary to process a Medicare or insurance claim.

_____ _____
Signature(or Parent/Guardian Date

For office use only:

Immunization 1:	Immunization 2	Immunization 3
Date:_____Med Staff:_____	Date:_____Med Staff:_____	Date:_____Med Staff:_____
Dosage:_____ _____	Dosage:_____ _____	Dosage:_____ _____
Injection site:_____ __	Injection site:_____ __	Injection site:_____ _
Manufacturer:_____	Manufacturer:_____	Manufacturer:_____

_____ Lot No._____ Exp:_____	_____ Lot No._____ Exp:_____	_____ Lot No._____ Exp:_____