ALLIANCE OCCUPATIONAL MEDICINE

315 S. Abbott Ave., Milpitas CA 95035 tel. 408-790-2900
2737 Walsh Ave., Santa Clara CA 95051 408-228-8400

Hepatitis B Vaccination Record S/E

Date (fecha) _____

_____ , _____ _____
Last Name (Apellido) First Name (Nombre) Social Security No.(Seguro Social)

_____ _____ _____ years sex ☐ F ☐ M
employer (empleador) job title (titulo de trabajo) age (edad)

Have you had a prior partial or complete Hepatitis B Vaccination? ☐ no ☐ yes/si
(Ha tenido antes vacunas parciales o completas de Hepatitis B?)

If you are pregnant, or think you may be pregnant, please request to speak with the physician or physicians assistant before receiving the vaccination.
(Si usted esta embarazada, o piensa que lo esta, porfavor pida hablar con su medico o asistente medico antes de recibir la vacuna.)

I consent to the administration of this Hepatits B Vaccine. I understand that to aquire maximal benefit I must receive all three vaccinations over the next 6 months as described in the patient information handout.
(Doy mi permiso a la administracion de esta vacuna Hepatitis B. Entiendo que para adquirir el maximo beneficio tengo que recibir las tres vacunas en el periodo de 6 meses, descritas en el folleto de informacion para el paciente.)

_____
patient signature / firma del paciente

I do <u>not</u> consent to the administration of the Hepatits B Vaccine. I understand that if I do not get the vaccine series I will be vulnerable to Hepatitis B infection which can cause serious illness or death. I may at any time during my employment change my mind and upon request receive the vaccine series.
(Yo <u>no</u> doy mi permiso para tomar la inyeccion del Hepatitis B. Entiendo que si no recibo las series de vacunas, sere vulnerable a la infeccion del Hepatitis B que puede causar seria enfermedad o muerte. Puedo en cualquier vez durante mi empleo, cambiar de opinion y pedir la serie de vacunas.)

PATIENT STOPS FILLING FORM HERE

_____
patient signature / firma del paciente

BP ____ / ____ Temp ____ F
Dose 1 date _____
Lot # : _____ Exp date: _____ 1ml IM

☐ Feeling well today
☐ No reaction in past to vaccination.
☐ VIS given, questions answered.
☐ R delt. ☐ L delt.

_____
medical assistant signature

BP ____ / ____ Temp ____ F
Dose 2 date _____
Lot # : _____ Exp date: _____ 1ml IM

☐ Feeling well today
☐ No reaction in past to vaccination.
☐ VIS given, questions answered.
☐ R delt. ☐ L delt.

_____
medical assistant signature

BP ____ / ____ Temp ____ F
Dose 3 date _____
Lot # : _____ Exp date: _____ 1ml IM

☐ Feeling well today
☐ No reaction in past to vaccination.
☐ VIS given, questions answered.
☐ R delt. ☐ L delt.

_____
medical assistant signature