INFORMED CONSENT FOR HEPATITIS B VACCINE

______ I authorize Physicians Quality Care to administer the Hepatitis B vaccine to me in an effort to provide immunization against Hepatitis B.

_____ I have read all the literature provided outlining possible side effects.

_____ I do not, at the present time, have any active infection.

_____ I am not pregnant, nor am I nursing an infant.

_____ I have no history of having Hepatitis B.

_____ I understand that a total of three injections will be required over the next 6 months to complete the series for the vaccine.

_____ I understand that the vaccination is voluntary and does not insure immunity in all cases. I hold Physicians Quality Care harmless if the vaccination does not result in immunity against Hepatitis B.

Signature____ Date______________________

Nurse Use Only:

<u>Hepatitis B Series</u>

Patient____________________________________ Date_________________________

DOB______________________________________ Sex__________________________

Company__________________________________ SSN__________________________

#1-Date_______ Lot#___________ Exp._______ Arm R L Initials_________

#2-Date_______ Lot#___________ Exp._______ Arm R L Initials_________

#3-Date_______ Lot#___________ Exp._______ Arm R L Initials_________

Thank you for choosing Physicians Quality Care for your health care needs. We look forward to working with you again in the future.