Pleasant Health Services, Inc.
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Hepatitis B Consent Form

Note: You must read the following information before signing and receiving the Hepatitis B vaccine.

What is Hepatitis B?

Hepatitis B virus is a serious disease caused by a virus that attacks the liver. The virus, which is called hepatitis B virus (HBV), can cause lifelong infection, cirrhosis (scarring) of the liver, liver cancer, liver failure, and death. Hepatitis B vaccine is available for all age groups to prevent hepatitis B virus infection. The following acute and chronic symptoms are manifested by the HBV disease.

Short-term (acute) Symptoms	**Long-term (chronic) Symptoms**
- loss of appetite - diarrhea and vomiting - tiredness - jaundice (yellow skin or eyes) - pain in muscles, joints, and stomach.	- liver damage (cirrhosis) - liver cancer - death

Please circle "Yes" or "No" for the following statements.

1.	I am under 20 years old.	Yes	No
2.	**One or more of the following applies to me:**		
	I am a health care or public safety worker who could be exposed to blood or body fluids.	Yes	No
	I recently had or was treated for a sexually transmitted disease.	Yes	No
	I had more than one sex partner during the last 6 months.	Yes	No
	I am a man who has sex with men.	Yes	No
	I have sex or live with a person with hepatitis B.	Yes	No
	I have had liver disease for a long time, or I have hepatitis C.	Yes	No
	I shoot drugs with needles.	Yes	No
	I have bad kidney disease.	Yes	No
	I provide direct services for people with developmental disabilities.	Yes	No
	I will live in Asia or Africa for more than 6 months.	Yes	No
	I come from Asia or the Pacific Islands.	Yes	No
	I have a blood-clotting disease.	Yes	No
		Yes	No
	If you answered "Yes" to any of the statements above, you may need the hepatitis B vaccine shot.		
3.	I have had hepatitis B infection or 3 hepatitis B vaccine shots.	Yes	No

For Clinic Use Only

Hepatitis B
Vaccine recommended ☐ Yes ☐ No Comments: _____
_____

Person Receiving Hepatitis B Vaccine

_____ _____ _____ ____
Name Daytime Phone # Birth Date Age

_____
Street Address City State Zip

_____
Signature (Person receiving vaccine)

_____ _____ _____ ☐ RA ☐ LA
Vaccination Date Manufacturer Name Lot No. Site of Injection

_____ _____
Administered by Date administered