

**MONTANA MENTAL HEALTH NURSING CARE CENTER
EXPOSURE CONTROL PLAN
HEPATITIS B VACCINATION SERIES CONSENT FORM**

Procedure:

1. Sign consent form to receive vaccine.
2. HBV (Hepatitis B Vaccine) is administered IM in the deltoid muscle at Days 0, 30 and 180 at no cost to the employee.
 - A. Dosage and administration: Engerix-B.
 1. Shake well before administering.
 2. Inject into deltoid muscle in adults.
 3. Pediatric dose: Newborn – 19 years of age. Three (3) doses of 0.5 ml (10 mcg).
 4. Adult dose: ≥ 20 years of age. Three (3) doses of 1 ml (20 mcg).
 - B. Dosage and administration: Recombivax HB.
 1. Shake well before administering.
 2. Inject into deltoid muscle in adults.
 3. Children age 11 – 19 years of age. Three (3) doses of 0.5 ml (5 mcg).
 4. Adult dose: ≥ 20 years of age. Three (3) doses of 1 ml (10 mcg).
3. Thirty days after the last dose of the vaccine is given, a serologic test to detect the presence of Hepatitis B antibodies may be done. MMHNCC does pay for and arranges this test with the employee if desired.
4. If the Hepatitis B antibody test shows inadequate protection, a booster dose of the vaccine may be given.

CONSENT:

I have read the Vaccine Information Statement (VIS) CDC publication about Hepatitis B Infection and Hepatitis B Vaccine. I have had the opportunity to ask questions. I understand the benefits and risks of vaccination. I understand that I must have three (3) doses of vaccine to confer immunity to Hepatitis B. However, as with all medical treatment, there is no guarantee I will become immune or that I will not experience any adverse side effects of the vaccine. I choose to receive the Hepatitis B Recombinant Vaccine. I hereby release the State of Montana, the Department of Health and Human Services, and any of its officials and employees from any liability incurred through normal operation of this program.

EMPLOYEE NAME: _____ DATE: _____
(PLEASE PRINT)

EMPLOYEE SIGNATURE: _____ DATE: _____

WITNESS NAME: _____ DATE: _____
(PLEASE PRINT)

WITNESS SIGNATURE: _____ DATE: _____

DATE	VACCINE	LOT	EXPIRATION	SITE	NURSE SIGNATURE