ADULT HEPATITIS A/HEPATITIS B VACCINE CONSENT FORM

FIRST NAME____________________**MIDDLE IN.**____**LAST NAME**____________________

ADDRESS________________________**CITY**________________**STATE**____**ZIP**________

BIRTH DATE________________**AGE**________**PHONE**______________**M**______**F**______

DR's NAME________________________ **Are you allergic to Yeast? YES NO**
circle

RACE: *(circle all that apply)* White Hispanic African American Asian Pacific Islander American Indian
ETHNICITY: *(circle all that apply)* White Hispanic African American Mixed Race

CASH__________ **CHECK**__________ **No Charge**___ **BILL INSURANCE**__________

NAME OF INSURANCE COMPANY:______________________**HMO**______**PPO**______

SUBSCRIBER NAME:__________________________________ **(as it appears on card)**

SUBSCRIBER ADDRESS:(if different than patient's only)________________________________

SUBSCRIBER DATE OF BIRTH:(if not the patient's) ________________________________

ID OR MEMBER NUMBER:(include all letters and numbers)______________________________

GROUP NUMBER:____

<u>BILL TO</u>: Paying Agency____

Agency Address____

Contact Person: ____

I have been given a copy and have read or have had explained to me the information on this form about Hepatitis A & Hepatitis B vaccine. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the Hepatitis A and Hepatitis B vaccine and request that it be given to me or to the person named above for whom I am authorized to make this request. I give permission to release this information to my physician.

______________________________ ______________________________
Signature Today's Date

4/10/2013 red **Date VFC Info Sheets Given:**____________________

HEP A/HEP B #1

Date Administered:______________________________

MFR/LOT#

Site of Injection______________

Nurse Signature:

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HEP A/HEP B #2

Date Administered:______________________________

MFR/LOT#

Site of Injection______________

Nurse Signature:

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HEP A/HEP B #3

Date Administered:______________________________

MFR/LOT#

Site of Injection______________

Nurse Signature:

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Comments:

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Livingston County Public Health Department
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Public Health
Prevent. Promote. Protect.