

PRE-EXPOSURE HEPATITIS VACCINATION STATUS REPORT

Minnesota Department of Corrections

EMPLOYEE NAME: _____ EMPLOYEE ID: _____

JOB CLASSIFICATION: _____ WORK SITE: _____

OSHA Standard 1910.1030 requires employers to offer the Hepatitis B vaccination to employees whose jobs involve exposure to blood and other potentially infectious materials.

CURRENT STATUS

Check the box if it applies to you:

- I have previously completed the vaccination series: approximate date or year: _____
- My immunity has been confirmed through antibody testing: approximate date or year: _____
- My physician states the vaccine is currently contraindicated for medical reasons.

DECLINATION/REFUSAL OF HEPATITIS B VACCINATION:

Complete this section if you do NOT want to receive the vaccination series.

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring the hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the hepatitis B vaccine at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the hepatitis B vaccine, I can receive the vaccination series at no charge to me.

EMPLOYEE'S SIGNATURE: _____ DATE: _____

CONSENT FOR HEPATITIS B VACCINATION

Complete this section if you want to receive the vaccination:

- I have received and read the Department of Corrections Pre-Exposure Hepatitis B Vaccine Information Sheet. I have had the opportunity to ask questions and understand the benefits and risks of hepatitis B vaccination. I understand that I must have three doses of the vaccine to confer immunity. However, as with all medical treatments, there is no guarantee that I will become immune or that I will not experience an adverse side effect from the vaccine.
- I consent to be immunized against hepatitis B by a licensed health care professional under the supervision of a physician.

EMPLOYEE'S SIGNATURE: _____ DATE: _____

HEALTHCARE EMPLOYEES ONLY

The CDC recommends that health care workers who have contact with patients or blood and are at ongoing risk for injuries with sharp instruments or needlesticks be tested for the antibody to hepatitis B surface antigen (anti-HBs) within 1 to 2 months after completion of the 3-dose vaccination series. The department will make this test available to health care employees at no cost.

- I consent to be tested for antibodies to hepatitis B surface antigen
- I have been previously tested for antibodies to hepatitis B surface antigen and know that I am immune.
Approximate date or year: _____

HEALTH CARE EMPLOYEE'S SIGNATURE: _____ DATE: _____