



### Hepatitis B Vaccine Consent or Declination Form

OSHA BBP Standard 1910.1030

**Instructions:** Refer to Guidance at end of document then select appropriate option regarding Hepatitis B. Complete the next section which documents your consent for UHS to provide your supervisor compliance with this OSHA requirement. Submit form to University Health Services [eh@uhs.wisc.edu](mailto:eh@uhs.wisc.edu)

#### Consent

I consent to receive the hepatitis B vaccination at this time. I have read the information on the following pages and had an opportunity to ask questions. I understand the benefits and risks of the vaccination as described.

Complete information below and on back of form then submit to [eh@uhs.wisc.edu](mailto:eh@uhs.wisc.edu). UHS Occupational Medicine Clinic will contact you to schedule appointment(s) for vaccine.

#### Declination—Previous Immunization

I have already received the Hepatitis B vaccination series, consisting of three shots. The series was provided by \_\_\_\_\_ and completed on \_\_\_\_\_.\*

Complete information below and on back of form. \*If series received outside of Wisconsin attach documentation of vaccine administration and submit to [eh@uhs.wisc.edu](mailto:eh@uhs.wisc.edu). Note: Failure to include documentation may delay appropriate treatment in the event of an exposure.

#### Declination

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with 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 hepatitis B vaccine, I can receive the vaccination series at no charge to me.

Department Name \_\_\_\_\_ Supervisor \_\_\_\_\_

Signature \_\_\_\_\_ Wisc ID# \_\_\_\_\_

Print Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

## CONTINUE ON NEXT PAGE



UHS Authorization to Release--OCCUPATIONAL HEALTH SERVICES

**Authorization required for Release of Health Information to UW Madison supervisory staff or safety coordinator staff.** In addition to the workplace medical surveillance and work-related injury and illness which are related to compliance with state and federal law, UHS can provide other occupational health and safety services to UW-Madison employees such as those related to animal contact. If you receive such services, we are required to obtain your written authorization before we can provide your health information related to these services to the UW-Madison supervisory staff, safety coordinator staff, PI, director (or designee) or your class instructor if you are a student. Patient Rights and Responsibilities is available at [www.uhs.wisc.edu](http://www.uhs.wisc.edu).

Occupational Health Information to be released is **preventive services** including: dates of vaccinations, proof of immune status to communicable disease, dates of tuberculosis screening, dates of respiratory fit testing and recommendations for personal protective equipment; dates of completion of animal health questionnaire, compliance with recommended surveillance programs, participation in Herpes B surveillance program and dates of Herpes B screenings (when working with non-human primates) for the purpose of meeting Occupational Health requirements. Aggregate test results will be reported to Occupational Health on a periodic basis for the purpose of evaluating workplace controls.

This authorization will remain in effect for as long as you are employed at UW-Madison unless otherwise stated:  
Additional Time period. Specify: \_\_\_\_\_ Include future records generated during the additional time period.  
I authorize release of my health records in accordance with the specifications listed above to UW supervisory staff (director or designee, PI on applicable protocols; UW safety coordinator staff; or UW class instructor (if applicable).  
Initial release should be sent to supervisor (class instructor, director, PI or other designee):  
Name: \_\_\_\_\_ Department: \_\_\_\_\_ E-mail: \_\_\_\_\_

I understand that I have a right to inspect and receive a copy of the disclosed material. A photocopy of this authorization shall be valid as the original.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Additional Information regarding disclosure of patient health information

University Health Services (UHS) honors a patient's right to confidentiality of health information as provided under federal and state law. Please read the following guidelines before signing this authorization.

**No obligation to sign.** You are under no obligation to sign this form, and you may refuse to do so.

**Revocation.** You have the right to revoke this authorization, in writing, at any time before it ends. However, your written revocation will not affect any disclosures of your health information that the person(s) and/or organization(s) listed on this form have already made, in reliance on this authorization, before the time revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and addressed to HIM (Medical Records), 333 East Campus Mall, #8104, Madison, WI 53715-1381.

**Re-Release.** If the person(s) and/or organization(s) authorized by this form to receive your health information are not health care providers or other people who are subject to federal health privacy laws, the health information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your health information without your prior permission.

**Right to inspect.** You have the right to inspect or copy the health information whose disclosure you are authorizing with certain exceptions provided under state and federal law. If you would like to inspect your records, contact HIM (Medical Records) at (608)-262-1676 for further information.

**Signatures.** Generally, if you are 18 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your health information. If you are under the age of 18, your parent or guardian must sign this form for you. However, there are many situations in which this general rule does not apply. For more information regarding who is authorized to sign this form, contact HIM (Medical Records), 333 East Campus Mall, #8104, Madison, WI 53715-1381 or call at (608)-262-1676.

## INFORMED CONSENT FOR HEPATITIS B VACCINE GUIDANCE DOCUMENT

1.0 Purpose: The purpose of this document is to provide information on the Hepatitis B vaccination regarding protective value and possible reasons to decline the series of vaccinations

Directions: Read the contents of this document prior to the individual's determination on whether to decline or receive the vaccination.

### The Disease

Hepatitis B is an infection of the liver caused by the hepatitis B virus (HBV). This disease comes in two forms--1) a subclinical form where the patient does not have symptoms but is still infectious; and, 2) an acute form where the patient is symptomatically ill for weeks to months, and where death occurs in 1-2% of cases. Long term complications result after either form of the disease in 5-10% of affected individuals, including: 1) chronic active hepatitis (liver enzymes remain elevated indicating that inflammation is continuing in the liver); 2) cirrhosis (scar tissue forms in the liver limiting the liver's ability to function); and, 3) in up to 10%, a long-term carrier state (virus remains in the blood and the individual remains capable of infecting others with hepatitis B). Furthermore, it is now felt that people who develop hepatitis B and continue to have hepatitis B surface antigen in their blood have a small but clearly greater risk of developing liver cancer later in life.

Hepatitis B is a major occupational risk for workers who are exposed to human blood and body fluids. This exposure results in certain high-risk workers, having two to three times as many cases of hepatitis B as the general population. Immunization against HBV can prevent acute hepatitis and reduce serious long-term virus associated complications such as chronic active hepatitis, cirrhosis, and liver cancer.

### Recombinant DNA Hepatitis B Vaccine

Recombinant hepatitis B vaccine is a non-infectious viral vaccine. It is derived from antigen produced in yeast cells and is free of human tissue or blood products.

Clinical studies have established that the recombinant hepatitis B vaccines when injected into the deltoid muscle induced levels of protective immunity in greater than 90% of healthy recipients who received the recommended 3 dose regimen.

### Possible Side Effects of the Vaccine

Recombinant hepatitis B vaccine is generally well tolerated. No serious adverse reactions or serious hypersensitivity reactions have been reported during clinical trials. The most common side effect is soreness at the injection site. Other infrequent side effects include fatigue, headache, malaise, low grade fever, nausea, and diarrhea.

### Contraindications

Hypersensitivity to any component of the vaccine.

Hepatitis B vaccine will not be given to pregnant or possibly pregnant women without their physician's written consent.

Employees who are at risk of acquiring hepatitis B infection as a result of occupational exposure and are not protected via the vaccine will be offered Hepatitis B Immune Globulin (HBIG) to prevent infection.

If you have any questions about hepatitis or hepatitis B vaccine, please ask your physician, one of the University Health Service practitioners or the Occupational Health specialist.

Date approved: 12/15/2010