MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*		ISSUANCE DATE
OCCUPATIONAL HEALTH PROGRAM	NAVHOSPPNCLAINST 6260.2G	01 Jul 2015

LOCAL FORM TITLE *(Optional)*
HEPATITIS B VACCINE CONSENT / DECLINATION SHEET (Health Care Professional's Written Opinion)

Date:_____

Clinic: NBHC _____

Ref: (a) OPNAVINST 5100.23 series
(b) 29 CFR 1910.1030
(c) NAVMED P-117

1. The below noted individual was examined according to current guidelines regarding exposure to blood and/or body fluid. On the basis of this examination the following comments are submitted:

2. There ☐ **ARE** ☐ **ARE NOT** recommended limitations upon the employee's ability to receive Hepatitis B vaccination. Limitations, if recommended, are bases on the following findings:

3. The employee has been informed of the results of this medical evaluation and about any medical conditions resulting from exposure to blood or other potentially infectious materials, which require further evaluation or treatment.

_____
Examiner's Signature and Stamp

I have read the statement about Hepatitis B and the Hepatitis B vaccine. I have had an opportunity to ask questions and understand the benefits and risks of Hepatitis B vaccine. I understand that I must have three doses of vaccine to confer full immunity. However, as with all medical treatment, there is no guarantee that I will become immune or that I will not experience any adverse side effects from the vaccine.

☐ I request to receive the three-dose Hepatitis B vaccine series.

_____
Patient's Signature

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 hepatitis vaccine at no charge to myself. However, I decline the Hepatitis vaccine 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 exposures and I want to be vaccinated with the hepatitis vaccine, I can receive the vaccination series at no charge to me.

☐ I decline to receive the HBV series.

_____
Patient's Signature

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	