Hepatitis B Vaccine Acceptance/Declination Form
For Minor Volunteer Participant

Due to your occupational exposure to blood or other potentially infectious material (OPIM) you may be at risk of acquiring hepatitis B virus (HBV) infection. Hepatitis B vaccination should be obtained through your personal health care provider. Post-Exposure Evaluation is provided from the Center for Occupational & Environmental Medicine (COEM) in Hillcrest at no cost to you.

Hepatitis B vaccination is recommended unless:
1) documentation of prior vaccination and post-vaccination titer is provided to EHS
2) medical evaluation identifies that vaccination is contraindicated.

If you have received prior Hepatitis B immunization, list the following three dates (month/year): _____, _____, _____ and provide documentation of the immunization and post-vaccine titer as soon as possible to the EHS Occupational Health Nurse at Fax# 858-534-7561 or mail code 0091.

Please choose one of the following options at the end of the training class (Note: you can change your decision at any time and discuss questions by contacting the EHS Occupational Health Nurse, 858-534-8225 or bsawtelle@ucsd.edu):

☐ I certify that I have been advised and will obtain the Hepatitis B Vaccination through my personal health care provider, including serological testing at 1-2 months post-vaccination. I will provide documentation of the vaccination and titer to the EHS Occupational Health Nurse at Fax# 858-534-7561 or mail code 0091.

☐ I understand that due to my occupational exposure to blood or OPIM 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 OPIM and I want to be vaccinated with hepatitis B vaccine, I will receive the vaccination series through my personal physician.

_____ _____
Signature of Minor Participant Date signed

Minor Participant Name (print) _____

_____ _____
Signature of Parent/Legal Guardian Date signed

Parent/Legal Guardian Name (print) _____

University of California Employee/Student Number (if applicable) _____

Dept. _____ Phone _____

Email address _____

Principal Investigator/Supervisor you will work for _____

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