



STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
CONSENT FOR HEPATITIS B IMMUNIZATION

I have read the statement "Important Information About Hepatitis B Vaccine." I have had an opportunity to ask questions and understand the benefits and risks of Hepatitis B vaccination. Ordinarily, it will take three doses of vaccine to confer immunity in thoroughly susceptible individuals. I understand that I must have all three doses of vaccine to confer immunity, depending on my current immune status. However, as with all medical treatment, there is no guarantee that I will become immune or that I will not experience an adverse side effect from the vaccine. I understand that it is my responsibility to report for vaccinations as scheduled, and failure to do so may result in a failure to confirm immunity to the Hepatitis B virus. In the event I fail to report for the vaccinations for any reason, I specifically release this facility, the mental health department, and its staff from all financial responsibility other than appropriate salary compensation, and/or accrued sick leave and insurance benefits should my ward/I develop acute Hepatitis B or any of its sequelae.

NAME OF PERSON TO RECEIVE VACCINE (PLEASE PRINT)

DOSE #	DATE ADMINISTERED	LOT #

SIGNATURE OF PERSON RECEIVING VACCINE OR GUARDIAN

DATE SIGNED

SIGNATURE OF WITNESS



STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
RELEASE FROM LIABILITY FOR HEPATITIS B

I have been advised by this facility that I should participate in the Hepatitis B immunization program. I have read the statement "Important Information About Hepatitis B Vaccine". I am a high risk client/employee, subject to exposure to Hepatitis B during my residence/employment. I understand that Hepatitis B vaccine has an 80 to 90 percent efficacy level in providing protection from Hepatitis B when complete series of three doses of vaccine are administered. I further understand that in addition to acute illness, Hepatitis B virus infection can lead to a chronic carrier state, chronic hepatitis, cirrhosis and is associated with a higher risk of liver cancer. I understand that there is no effective treatment or cure for Hepatitis B.

I elect that the person named below of whom I am the parent or guardian not participate/I elect not to participate in the Hepatitis B immunization program.

I, therefore, release this facility, the mental health department and its staff from all financial responsibility other than appropriate salary compensation, and/or accrued sick leave and insurance benefits should my ward/I develop acute Hepatitis B or any of its sequelae.

CLIENT/EMPLOYEE NAME (PLEASE PRINT)

CLIENT/EMPLOYEE/GUARDIAN SIGNATURE

DATE

WITNESS SIGNATURE

DATE