NAME (PRINT) ______________________________

SSN ____________________________________

HEPATITIS B IMMUNIZATION FORM
ILLINOIS COLLEGE OF OPTOMETRY / ILLINOIS EYE INSTITUTE

It is my opinion that ______________________________ should and is physically able to receive the Hepatitis B (HBV) vaccine.

____ ___________
Signature of Physician/Primary Health Care Provider Date

Consent

I agree to receive the HBV vaccine and to release from liability and hold forever harmless the Illinois College of Optometry / Illinois Eye Institute, the facility, its directors, officers, medical staff, employees, representative, agents and assigns for any illness, injury, condition or damage which is directly of indirectly attributable to the vaccination procedure, whether it arises during or at any time after the procedure. I realize that this does not release the aforementioned parties from liability for their negligent acts or omissions.

By signing this form, I authorize, consent to and request the performance of HBV vaccination procedure and any treatment which the facility physician or his/her designees deem necessary in order to respond to and care to unforeseen events of condition which may arise during the course of this vaccination.

I acknowledge that I have read this document in its entirety and that I fully understand it.

____________________________________ ________________________ ____________
Signature Witness Date

Date	Site of vaccination:	Lot #	Signature of person(s) administering vaccine:
1.____________	________________	___________	____________________________
2.____________	________________	___________	____________________________
3.____________	________________	___________	____________________________