IRMS: Hepatitis Vaccine Project **Facility** ______________________________

Complete ALL information for each entry and please print legibly. Fax forms bi-weekly to 558-6478

Patient [ ] First [ ] Middle [ ] Last [ ]

Phone [ ] **DOB** [ ] **Gender: M** [ ] **F** [ ]

Physical Address [ ] **County** [ ]

City [ ] **State** [ ] **Zip** [ ]

Patient Race __Am. Indian or Alaskan Native
__Native Hawaiian or Other Pacific Islander
__White __African American __Asian

Patient Ethnicity
__Hispanic __Non-Hispanic
__Unknown

Vaccine Type					
Vaccination Date					
Manufacturer/ Lot Number					
Lot Expiration					

By signing the consent below, I certify that I received the Vaccine Information Statement for the vaccine I will receive. I understand the risks and benefits of vaccination and have been given the opportunity to ask questions about the vaccine.

*Patient Signature ____Date_____/_____/_______

Signature of Vaccinator ____ Date____/_____/________

*Patient Signature ____Date_____/_____/_______

Signature of Vaccinator ____ Date____/_____/________

*Patient Signature ____Date_____/_____/_______

Signature of Vaccinator ____ Date____/_____/________

*Patient Signature ____Date_____/_____/_______

Signature of Vaccinator ____ Date____/_____/________

Transferred or Released on Date: ______________________________ **Next Dose Due:** _______________

Refer to: ____________________________________**County Health Department** **Phone #:** ___________________

Transferred to:_________________________ __________________________ **Phone #**___________________

Submit to: WVDHHR/BPH STD Program, 350 Capitol St. Room 125, Charleston, WV 25301 or Fax (304)558-6478