

## Hepatitis B Viral Infections - Pre-vaccination Health Questionnaire & Consent Form

**Name of Employee:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Job Position:** \_\_\_\_\_

**Address:** \_\_\_\_\_

Please answer the following questions, indicate whether you consent to having \_\_\_\_\_ vaccination(s), and sign and date the Form in the space provided. If you answer "yes" to any question please provide details:

	Element	YES	NO	Further Details
1	Are you presently suffering from a cold, sore throat, gastro-intestinal upset, or any other infection or illness?	<input type="checkbox"/>	<input type="checkbox"/>	
2	Do you have any blood disorder or immune deficiency?	<input type="checkbox"/>	<input type="checkbox"/>	
3	Do you have any allergies?	<input type="checkbox"/>	<input type="checkbox"/>	
4	Have you ever had an adverse reaction to any vaccination?	<input type="checkbox"/>	<input type="checkbox"/>	
5	Do you have any skin disorders such as eczema, dermatitis or psoriasis?	<input type="checkbox"/>	<input type="checkbox"/>	
6	Are you currently taking any medication, including steroids or immune-suppressants?	<input type="checkbox"/>	<input type="checkbox"/>	
7	Is there a chance that you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	
8	Are you currently breast-feeding?	<input type="checkbox"/>	<input type="checkbox"/>	
9	Have you had any other vaccinations or immunisations in the last 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	

**Please note that if you are HIV+** you should inform the occupational nurse or physician. Any information given will be treated in the strictest confidence.

**DECLARATION:**

The above answers to the questionnaire are true to the best of my knowledge and belief.

I consent / do not consent to have the above vaccination(s):

Signature: \_\_\_\_\_ Date: \_\_\_\_\_