Vaccine Administration Record - Hepatitis A

Name ________________________________ **Date** ______________

Employer/Department ____

SSN ____________________ **Med. Record Number** ______________

PLEASE PRINT

Have you ever had a reaction to the hepatitis A vaccine? ___ Yes ___ No

If yes, please explains: ____

Are you allergic to formaldehyde? ___ Yes ___ No

Do you have any bleeding disorders or are you taking any medicine to thin your blood? ___ Yes ___ No

Are you currently sick with any acute or chronic illness? ___ Yes ___ No

If yes, please explains: ____

If female, is there any chance you could be pregnant? ___ Yes ___ No

If female, are you breast-feeding? ___ Yes ___ No

I have read or have had explained to me the information about the hepatitis A vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the hepatitis A vaccine. I request that the vaccine be given to me.

Signature ________________________________ Date ___________

DO NOT WRITE BELOW THIS LINE

Manufacturer ______________ Lot # _________ Expiration Date ___________

Dose: 1 ml Site of Injection ___ Right Deltoid ___ Left Deltoid

Injection Time ______________ No reactions after _______ minutes of observation

Reaction, if any: ______________________ VIS Given? ______________

______________________________ ______________

Signature of Vaccine Administrator Date/Time

Vaccination Number ______ 1 ______ 2