**Student Waiver to Decline the Hepatitis B Vaccination**

***NOTE: This form should be discussed with the physician/nurse practitioner/physician assistant of your choice, signed and returned with all other health forms.***

**Please read the information enclosed in the handbook from the Department of Health and Human Services, Centers for Disease Control and Prevention on hepatitis B and the hepatitis B vaccine. If you have any questions about hepatitis B or the hepatitis B vaccine, please discuss those with your physician/nurse practitioner/physician assistant.**

By signing this wavier I indicate that:

I have been given the instruction to be vaccinated with the hepatitis B vaccine at my own expense if my insurance company does not cover the cost.

I understand that if I am a current employee in a health care facility and have a potential exposure to blood, my employer is responsible for the cost of the hepatitis B vaccination.

I have discussed hepatitis B and the hepatitis B vaccine with my physician/nurse practitioner/ physician assistant and have read the Department of Health and Human Services, Centers for Disease Control and Prevention vaccine information statement about hepatitis B and the hepatitis B vaccine.

I have had an opportunity to ask my physician/nurse practitioner/ physician assistant questions and understand the benefits and risks of the hepatitis B vaccination.

I understand that I may be at risk of acquiring hepatitis B virus (HBV) infection due to my exposure to blood or other potentially infectious materials during my clinical experience.

I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B.

I understand that by declining the hepatitis B vaccination, certain clinical sites may not accept me as a student.

I understand the benefits and risks of the hepatitis B vaccine and **I do not** wish to receive the vaccine.

I hereby I release Hawkeye Community College and my clinical site of any responsibility should I contract hepatitis B due to exposure during my clinical education experience as a student.

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Name of Person Declining Vaccine (Please Print) Program

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Signature of Person Declining Vaccine Date

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Signature of Parent or Guardian if student is a minor Date

***If you are declining the Hepatitis B series,*** *please sign and return completed form to PTA Program Director.*

*04/14/2022ms*