CHET JOHNSON DRUG
Amery, Wisconsin

Hepatitis B

Vaccination

Please fill out the requested information completely:

1) Name: _____ Birthdate: _____
2) Which arm would you like to use? ☐ LEFT ☐ RIGHT
3) Allergies:
   - ☐ No allergies
   - ☐ Latex
   - ☐ Other vaccines or vaccine components: _____
   - ☐ Other allergies: _____
4) Are you currently pregnant or breast feeding?
   - ☐ No ☐ Yes
5) I am an adult 20 to 59 years old and have never completed or don't know if I have completed a series of hepatitis B vaccinations (HepB)
   - ☐ No ☐ Yes
6) I am an adult 60 years or older, have never completed a HepB series, and want to be protected from hepatitis B infection.
   - ☐ No ☐ Yes
7) I am an adult 60 years or older, have never completed a HepB series, and have one or more of the following risk factors:
   - I am a sex partner of someone who has hepatitis B virus infection.
   - I am sexually active but am not in a long-term, mutually monogamous relationship.
   - I have been evaluated or treated for a sexually transmitted disease.
   - I am a man who has sex with men.
   - I use injection drugs.
   - I am a household contact of someone who has chronic hepatitis B virus infection.
   - I work or live in a facility for developmentally disabled persons.
   - I am a healthcare or public safely worker who might be exposed to blood or blood-contaminated body fluids.
   - I am currently receiving dialysis or may be receiving it in the future.
   - I have human immunodeficiency virus (HIV) infection.
   - I have diabetes.
   - I am planning to travel in an area of the world where hepatitis B is common.
   - I have hepatitis C infection.
   - I have chronic liver disease.
   - I am or was recently in prison.

8) We will add a record of this vaccination to the Wisconsin Immunization Registry (WIR) to keep your records with your other health care providers up-to-date. You may decline to be added to WIR; it will then be your responsibility to notify your health care providers as needed. If you do NOT want this vaccination added to the WIR, check this box:

☐ Do NOT submit a record of this vaccination to the Wisconsin Immunization Registry

9) Please sign and date:

Signature: _____ Date: _____

Please provide your insurance card(s) with this form if you want the vaccine billed to insurance.