|  |  |  |
| --- | --- | --- |
| **Full Name:** |  | |
| **Date of Birth** |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Question** | **Yes** | | **No** | **Please provide further information** |
| Do you have an illness, high temperature or current infection? |  | |  |  |
| Have you ever experienced a severe reaction to any vaccination in the past? |  | |  |  |
| Do you have any bleeding disorder or been prescribed an anticoagulant treatment? |  | |  |  |
| Have you previously received the Hepatitis A or B vaccination? |  | |  |  |
| Do you have any allergies, or have you ever experienced an anaphylactic reaction? |  | |  |  |
| **If you have answered ‘YES’ to any of the questions above or have any other concerns, please discuss these with the nurse prior to receiving any vaccine.**  **I have read and understood the information discussed with me about immunisation including the risk of the vaccination and the risk of not being vaccinated. I have been given the opportunity to discuss the risks and benefits with the OH Nurse and consent to be vaccinated.** | | | | |
| **Signed:** | | **Date:** | | |

**For use by Occupational Health staff only:**

|  |  |  |
| --- | --- | --- |
| **Vaccinator Name** | **Vaccinator Signature** | **Date** |
|  |  |  |
| **Vaccination administered.**  **Twinrix / Hepatitis A / Hepatitis B vaccination\* (please delete).** | **Expiry date / batch number (attach label from syringe barrel)** | **Site** |
|  |  |
| **Any adverse events noted during or after vaccination have taken place?** | | |
|  | | |
| **Any additional information given?** | | |
|  | | |