

HEPATITIS B CONSENT FORM

WHAT IS HEPATITIS B?

Hepatitis B is an infection of the liver caused by a virus. Some people who get Hepatitis never feel sick. Others develop flu-like symptoms, such as fatigue and nausea. Some become very ill with fever, abdominal pain, dark urine, clay coloured stools and jaundice (yellowish colour of the skin and eyes). Hepatitis B infection leads to death in about 1 in 100 cases. If you are infected with Hepatitis B (whether you show symptoms or not) you can pass the virus to others.

Six to ten percent of people with hepatitis B become chronic or lifetime carriers of hepatitis B and **can** pass the infection to others. Carriers look healthy but many may develop cirrhosis or cancer of the liver later in life.

HOW IS HEPATITIS B SPREAD?

The virus is spread from person to person when body fluids are passed between people. The kinds of body fluids that spread Hepatitis B are:

- Blood
- Semen
- Vaginal fluid
- Saliva
- Breast milk

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HEPATITIS B IMMUNIZATION RECORD

Student's name: _____

Date of Birth: _____

1. _____

2. _____

Keep this important record with your personal health files when the two injections have been given.

If your child has already had the vaccine, please provide the dates above and return.

Unless cancelled, this request is valid for the time period needed to give the two doses of vaccine.

Hepatitis B can be spread the following ways:

- Tattooing or body piercing with unsterilized equipment/ink
- Sharing razors, nail files, or toothbrushes
- Having unprotected sex
- Needle stick injuries in health care workers
- Blood splashes on the eye, nose, mouth or broken skin
- Sharing needles or other equipment for drug use
- From a woman to her baby during birth or while she is pregnant
- From a woman to her baby during breast feeding

Hepatitis B is **NOT** spread by touching, hugging, sneezing, coughing, or sharing dishes or eating utensils.

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REQUEST FOR HEPATITIS B IMMUNIZATION

Last Name _____

First Name _____

Sex: male/female

Date of Birth : year _____ month _____ day _____

Health Card #:

School: _____ Room: _____

I have read or had explained to me this information about the vaccine. I have had the chance to ask questions, which were answered to my satisfaction.

I ASK THAT THE ABOVE NAMED BE VACCINATED AGAINST HEPATITIS B (TWO DOSES).

Date: _____ Signature: _____

Phone #: home _____ bus. _____

Parent/Guardian/ (please print)

HEPATITIS B CAN BE PREVENTED

The Ministry of Health has a voluntary Hepatitis B vaccination program available to all students in Ontario. The vaccine is given at an age before most chances of being exposed to the virus occur. The Hepatitis B vaccine offered at school clinics involves two separate injections given four to six months apart during the school year. Vaccinations for Hepatitis B are voluntary and both injections are needed to be fully protected.

IS THE VACCINE SAFE?

This vaccine is one of the safest vaccines around. Although side effects are rare, the most common side effects of the vaccine are:

- Redness, soreness, and swelling at the injection site
- Other reactions may include fever, headache, nausea, dizziness, fatigue, joint pain, and rashes and should subside in 1 to 2 days
- Allergic reactions like hives, wheezing, swelling of the face and mouth are rare. However, if these symptoms occur, seek medical attention immediately and inform the Health Unit
- There are other extremely rare but serious side effects reported but NOT proven to be associated with the vaccine. These can be found at www.merckfrosst.ca (recombivax)

WHO SHOULD NOT GET THE HEPATITIS B VACCINE?

- Those who have an allergy to any component of this vaccine including yeast, thimerosal (contact lens solution), aluminium, or mercury
- Anyone who has had a severe reaction to this vaccine in the past
- Anyone who has a temperature (fever) or acute illness
- Anyone who may be pregnant

PARENTS/GUARDIANS

If you wish to immunize your child for Hepatitis B:

- Please complete and sign the consent form on the front of this form and return it to the school
- Please keep the rest of this form for your information

For more information, please contact:

The Vaccine Preventable Diseases program at the Leeds, Grenville and Lanark District Health Unit at 613-345-5685 or 1-800-660-5853

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FOR NURSE'S USE ONLY:

VACCINE: Recombivax 1.0 mL intramuscular

#1 Right/left

deltoid	date	time	lot #
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Nurse's signature: _____

#2 Right/left

deltoid	date	time	lot #
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Nurse's signature: _____

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This information is collected under the authority of Sections 2 and 5 of the **Health Protection and Promotion Act** and Ont. Reg 585/94 under the **Health Cards and Numbers Control Act** and Section 11 under the **Immunization of School Pupils Act** for the purpose of maintaining an immunization record for this student. For more information, contact the Freedom of Information Co-ordinator at your public health unit.