MSM Clinical Affairs
Student Health and Wellness Center
455 Lee Street 3rd Floor Suite 300-A
Atlanta, Ga. 30310
HEPATITIS B VACCINE AUTHORIZATION

HEPATITIS B:
Hepatitis B is a virus that can cause severe inflammation of the liver, called Hepatitis. Hepatitis itself may lead to chronic liver disease or liver cancer. In some people, the virus causes mild flu-like symptoms; in others it causes death. Although most people recover from the disease, some may become chronic carriers of the virus and may transmit the disease to others. One third of people infected with the Hepatitis B virus will have such mild case that they will feel no symptoms and will not know they have the disease. Hepatitis B is a strong virus that resists the usual practices of hygiene. It is far more difficult to kill outside the body than the AIDS virus. Hepatitis B can live for over a week in dried blood, sweat, or saliva on clothing or surfaces. It lives in most body fluids such as blood, semen, vaginal secretions, urine, saliva, and sweat.
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THE VACCINE:
The newest hepatitis B vaccine, Recombivax HB, is a noninfectious, synthetic vaccine. It is given by injection in the arm at 0, 1, 6 months. Recombivax HB will prevent hepatitis B and hepatitis due to the delta agent. It will not prevent hepatitis A or hepatitis non-A/non-B.

ADVERSE REACTIONS:
Recipients of the vaccine may experience local reactions such as soreness, redness, and swelling at the injection site. These reactions are mild and generally subside within two days of vaccination. A low-grade fever occurs occasionally. Other complaints may include fatigue, malaise, headache, nausea, and dizziness.

CONTRAINDICATIONS:
Recombivax HB is contraindicated in individuals who are hypersensitive to yeast or any other components of the vaccine. This vaccine is not recommended for use in pregnant woman and nursing mothers. Any serious active infection is reason for delaying use. Persons with immunodeficiency or those receiving immuno-suppressive therapies should have authorization from their private physician. Also, persons with severed compromised cardio-pulmonary status or those in whom a febrile or systemic reaction could pose a significant risk should have authorization from their physician.

AUTHORIZATION: Print Name_____

I_____ authorize the Morehouse Healthcare, Student Health and Wellness Center to administer Recombivax HB vaccine to me. I have read the above information and understand the risks and possible adverse reactions of the drug. The proposed procedure has been satisfactorily explained to me and I have all the information I desire. I acknowledge that no guarantee or assurance has been made to me as to the results that may be obtained and will not hold MOREHOUSE HEALTHCARE responsible for any untoward effects.

Dose	**(1)** _____	**(2)** _____	**(3)** _____
Lot #	_____	_____	_____
Exp.	_____	_____	_____
Site	_____	_____	_____
HCP sign	_____	_____	_____
Date	_____	_____	_____

Revised 10/2020