I have read the vaccine information statements or have had the information explained to me about the following:

- Tetanus and Diphtheria Vaccine
- Hepatitis B Vaccine
- Hepatitis B Immune Globulin

Indicate below whether you accept or decline the vaccines.

- **ACCEPT:**
  
  I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and authorize the healthcare worker to administer the vaccine(s).

  Signature of the person to receive the vaccine(s) __________________________ Date __________

- **DECLINE:**
  
  I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) and decline the vaccine(s) at this time. I understand I may retract my decision and receive the vaccine at a later date, although consequences due to the delay may result.

  Signature of the person to receive the vaccine(s) __________________________ Date __________

**For healthcare employee to complete:**

- **Tetanus and Diphtheria Vaccine:** Date administered __________________________
  
  Manufacturer and lot number: ____________________________________________
  
  Injection site: __________________________________________________________

  _____________________________________________ Date __________
  
  Qualified Health Care Provider Signature

- **Hepatitis B Vaccine:** Date administered __________________________
  
  Manufacturer and lot number: ____________________________________________
  
  Injection site: __________________________________________________________

  _____________________________________________ Date __________
  
  Qualified Health Care Provider Signature

- **Hepatitis B Immune Globulin:** Date administered __________________________
  
  Manufacturer and lot number: ____________________________________________
  
  Injection site: __________________________________________________________

  _____________________________________________ Date __________
  
  Qualified Health Care Provider Signature