

**HEPATITIS B IMMUNIZATION PROGRAM**  
 Primary Care Center – Banner Health Occupational Health Services

AGENCY: Kyrene School District – P.O. # \_\_\_\_\_

**BILLING ADDRESS:**  
 Banner Health Occupation Health Services  
 1441 12<sup>th</sup> Street, 3<sup>rd</sup> Floor  
 Phoenix, AZ 85006

PROGRAM DATE: \_\_\_\_\_

PROGRAM LOCATION: Banner Health  
 Banner Health Occupational Health Services  
 2225 W. Southern  
 Mesa, Arizona

**VACCINE INFORMATION**

**PROVIDER SIGNATURES**

Manufacturer: \_\_\_\_\_  
 Lot Number: \_\_\_\_\_  
 Expiration Date: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I have read or had explained to me the information contained in the Important Information Statement about the HEPATITIS B VACCINE (ADHS Consent Form 103B 8/90). I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request that the Hepatitis B vaccine be given to me.

EMPLOYEE NAME	EMPLOYEE SIGNATURE	NURSE (Initial/Site/Date)		
		1	2	3

Kyrene will pay for the Hepatitis B vaccination for the following employees who may be at increased risk of exposure: Health Services staff and substitutes, coaches, special education teachers/aides, special education bus drivers/aides, preschool teachers/aides, and Kid’s Club instructional aides.

Other Kyrene employees desiring the Hepatitis B vaccination will pay for the cost of their own vaccination.

**THIS FORM MUST ACCOMPANY BILL.**