Deansgrange Medical Centre
2 Clonkeen Road, Blackrock,
Co. Dublin.

Hep B Immunisation Consent Form

Patient's name & DOB: (place addressograph here)

1st Visit: Lot Number: **Expiry date:**

2nd Visit: Lot Number: **Expiry date:**

3rd Visit: Lot Number: **Expiry date:**

*Booster is needed 1 year from 1st shot if on accelerated schedule

Booster: lot number: **Expiry date:**

I have been fully informed about the above vaccine and which disease it provides protection against, the possible side effects, when they might occur and how they should be treated. I confirm by signing this form that I'm authorising consent on behalf of myself or the above named child. I consent for these vaccines to be administered to me/my child.

Patient or Parent/Legal Guardian signature: _____

Date: _____

1st visit administered by: _____ **Date: _____**

2nd visit administered by: _____ **Date: _____**

3rd visit administered by: _____ **Date: _____**

Booster administered by: _____ **Date: _____**