FIRELANDSHEALTH
Firelands Regional Medical Center

CENTER FOR WOMEN AND NEWBORNS

VISITATION GUIDELINES

Congratulations on the birth of your newest family member! At Firelands Regional Medical Center we realize visits are important to mothers as you celebrate your new baby's arrival. The following are some visitation guidelines for your stay.

- OB visitation is limited to:
  Labor- 2 designated individuals throughout your labor and delivery.
  Postpartum- 1 designated overnight visitor to stay throughout your hospitalization.
- Open visitation is allowed in Postpartum **only** for all other visitors from 10:00 AM-12:00 PM and 5:00 PM-8:30 PM. No other children under the age of 18 permitted visitation, unless siblings of the newborn.
- Rooming-in with your infant is encouraged. However, you may request for your infant to stay in the nursery and be viewed through the windows during visitation.
- All visitors must thoroughly wash their hands at the sink in your room before touching the baby**.**
- Please be sure that any family member or visitor that you allow to come in contact with your baby is free of any illness or contagious condition (cold, flu, fever, etc.) All visitors and family members must remain masked at all times.
- If you would like time alone to rest, shower, sleep, nurse your infant, or prefer to have private time without interruption, please let the nurse know.
- Your designated overnight guest will be given a special ID bracelet and must be 18 years of age.
- Overnight guests will be awakened along with the mother to provide the opportunity to assist and learn to care for the infant.
- Overnight guests must provide their own meals, provide for and take care of their own hygiene needs, and be appropriately dressed at all times including shoes/ slippers when walking in the hallways.
- Overnight guests will be provided with a pillow, blanket, towels, and washcloths as needed.
- Please discuss any visitation concerns or special circumstances with your nurse.

Thank you for choosing Firelands Regional Medical Center!

FIRELANDSHEALTH
Firelands Regional Medical Center

* C B W S *

Patient's Label

BIRTH PARENT WORKSHEET
FOR THE CERTIFICATE OF LIVE BIRTH

You must provide complete and accurate information to all questions on this worksheet. The information you provide will be used to create your child's birth certificate. The birth certificate is a permanent legal record that will be used by your child throughout their life for important purposes such as proof of age, citizenship, and parentage.

In addition, health researchers use this information to study and improve the health of mothers and infants. Items such as education, race, and smoking will be used for studies but will not appear on copies of your child's birth certificate (unless requested by a person listed on the certificate). State of Ohio law provides protection against the unauthorized release of health and medical information but mandates the release of identifying information from the birth certificate under public record law. Please print clearly in black or dark blue ink. If needed, please ask hospital staff for help.

CHILD INFORMATION			
Child's Legal Name as it should appear on the birth certificate:			
First	Middle	Last	Suffix
Date of Birth:	Time of Birth: _____:_____ ☐AM ☐PM	Sex: ☐ Male ☐ Female	
If multiple, this worksheet is for: ☐ First ☐ Second ☐ Third			

SOCIAL SECURITY NUMBER

Do you want to request a Social Security Number for your child? ☐ **Yes** ☐ **No**

I request that the Social Security Administration assign a Social Security number to the child named on this form and authorize the State to provide the Social Security Administration with the information from this form which is needed to assign a number.

I understand that if I was married at any time during the 300 days prior to birth of this child, my spouse is presumed to be the other parent. This can only be overruled by legal documentation (court order, separation agreement, journal entry, divorce decree) stating my spouse should not be listed as a parent. If no such documentation is presented and I do not agree to list my spouse as a parent, the birth record will not be electronically transmitted to the Social Security Administration and a birth certificate will not be available for purchase.

Signature of birth parent:	**Date:**

BIRTH PARENT INFORMATION

Preferred Parentage Title (to be on your child's Birth Certificate): ☐ Mother ☐ Father ☐ Parent

Birth Parent Current Legal Name:

First	Middle	Last	Suffix

Birth Parent Date of Birth:	Age:

Birth Parent Name Prior to First Marriage: ☐ Same as above

First	Middle	Last	Suffix

SOCIAL SECURITY INFORMATION

Furnishing parent(s) Social Security number(s) (SSNs) is required by Federal Law, 42 USC 405c section 205c of the Social Security Act. The number(s) will be made available to state and local social services agencies to assist with child support enforcement activities and to the Internal Revenue Service for the purpose of determining Earned Income Tax Credit compliance. The SSN is also collected as authorized by Ohio law to be used for public health purposes.

What is your Social Security Number? If you do not have a Social Security number, mark "None."

				–				–				

☐ None

BIRTH PARENT PLACE OF BIRTH

Birth Parent Place of Birth (**Specify** either U.S. **state**, **territory** or **country**)

_____, _____, _____

State (specify) Territory (specify) OR Foreign Country (specify)

BIRTH PARENT RESIDENT ADDRESS

Residence Street Number and Name:

Zip Code:	City:	County:

State:	Country:

Is current residence located inside city limits? ☐ Yes ☐ No

BIRTH PARENT MAILING ADDRESS (IF DIFFERENT FROM RESIDENCE ADDRESS)

Mailing Address Street Number and Name: ☐ Check if same as resident address

Zip Code:	City:	County:
State:	Country:	

BIRTH PARENT TELEPHONE

Primary Phone Number ( )	Secondary Phone Number ( )
☐ I do not have a phone number where I can be contacted	Phone Type: ☐ Cell ☐ Other ☐ Work

BIRTH PARENT ATTRIBUTES

What is the highest level of education you have completed? (Check only one)

- ☐ 8th Grade or less
- ☐ 9th-12th grade, no diploma
- ☐ High school graduate or GED completed
- ☐ Some college, but no degree
- ☐ Associate degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Doctorate or Professional Degree

What is your primary language (the language that you feel most comfortable speaking)?

- ☐ English
- ☐ Spanish
- ☐ Pennsylvania Dutch/ Deitsch/ Pennsylvania German
- ☐ Somali
- ☐ Nepali
- ☐ Arabic
- ☐ French
- ☐ German
- ☐ Other (**Specify**):_____

Are you of Hispanic Origin? (Check all that apply)

- ☐ No, not Hispanic
- ☐ Yes, Mexican
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, Other Hispanic Origin (**Specify**): **:**_____

What is your race? (Check all that apply)

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native (**Specify tribe**): _____
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (**Specify**): _____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander (**Specify**): _____
- ☐ Other (**Specify**): _____

BIRTH PARENT HEALTH

Did you receive WIC (women, Infants & Children) assistance during this pregnancy? ☐ Yes ☐ No

What is your height	What was your weight **before** pregnancy?
_____feet_____inches	_____pounds

Did you smoke cigarettes during this pregnancy? ☐ Yes ☐ No

If you, please specify the **daily** average number of cigarettes smoked **per day** for each time frame below:

Three months before pregnancy _____

First three months of pregnancy _____

Second three months of pregnancy _____

Last three months of pregnancy _____

Did you use alcohol during this pregnancy? ☐ Yes ☐ No

If yes, please specify the average number of alcoholic drinks **per day** for each time frame below:

Three months *before* pregnancy _____

First three months of pregnancy _____

Second three months of pregnancy _____

Last three months of pregnancy _____

Did you use cannabis during this pregnancy? ☐ Yes ☐ No

If yes, please specify the type of use (select all that apply):

☐ Smoking ☐ Vaping ☐ Other (Specify):

☐ Oils ☐ Edibles

FIRELANDSHEALTH
Firelands Regional Medical Center

BIRTH PARENT MARITAL STATUS –
REQUIRED TO REGISTER BIRTH RECORD AND ESTABLISH PARENTAGE

Were you married at the time you conceived this child, at the time of birth, or within 300 days prior to the birth of your child?

☐ YES (continue to **SECOND PARENT INFORMATION**)

☐ YES, but I can provide legal documentation (court order, separation agreement, journal entry, or divorce decree) stating my spouse is not to be listed as the parent of my child.
(continue to **ACKNOWLEDGMENT OF PATERNITY**)
*Documentation is subject to approval by the Ohio Department of Health, Bureau of Vital Statistics

☐ YES, but I refuse to provide my spouse's name as the parent of my child. (continue to **INFORMANT**) *Please note that under the State of Ohio law; by refusing to complete your spouse's information, your child's birth certificate will not be registered as a legal document and your child's birth information will not be electronically transmitted for a Social Security number to be issued.

☐ NO (continue to **ACKNOWLEDGMENT OF PATERNITY**)

ACKNOWLEDGMENT OF PATERNITY

Has the Acknowledgment of Paternity form been completed? That is, will you and the biological father be signing an Acknowledgment of Paternity (AOP) form in the hospital.

☐ Yes

☐ No (Continue to **INFORMANT**)
*If you were not married, or if an **Acknowledgment** of Paternity form has not been completed, information about the father cannot be included on the birth certificate.

If not signed in the facility, does the parent intend to file an Acknowledgment of Paternity?

☐ Yes ☐ No ☐ Not Applicable

FIRELANDSHEALTH
Firelands Regional Medical Center

BIRTH PARENT INFORMATION

Preferred Parentage Title (to be on your child's Birth Certificate**):** ☐ Mother ☐ Father ☐ Parent

Second Parent Current Legal Name:

First	Middle	Last	Suffix

Second Parent Name Prior to First Marriage (if applicable):

First	Middle	Last	Suffix

SECOND PARENT SOCIAL SECURITY INFORMATION

Furnishing parent(s) Social Security number(s) (SSNs) is required by Federal Law, 42 USC 405c section 205c of the Social Security Act. The number(s) will be made available to state and local social services agencies to assist with child support enforcement activities and to the Internal Revenue Service for the purpose of determining Earned Income Tax Credit compliance. The SSN is also collected as authorized by Ohio law to be used for public health purposes.

What is your Social Security Number? If you do not have a Social Security number, mark "None."

				–				–				

☐ None

SECOND PARENT PLACE OF BIRTH

Birth Parent Place of Birth (Check only one and **specify** either U.S. **state**, **territory** or **country**)

_____, _____, _____

State (Specify) Territory (Specify) OR Foreign Country (Specify)

SECOND PARENT CURRENT RESIDENCE

Only complete this section if an Acknowledgment of Paternity will be signed in the facility

Residence Street Number and Name:

Zip Code:	City:	County:
State:	Country:	Phone Number:

Is current residence located inside city limits? ☐ Yes ☐ No

SECOND PARENT ATTRIBUTES

What is the highest level of education completed by the second parent? (Check only one)

- ☐ 8th Grade or less
- ☐ 9th-12th grade, no diploma
- ☐ High school graduate or GED completed
- ☐ Some college, but no degree
- ☐ Associate degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Doctorate or Professional Degree

Are you of Hispanic Origin? (Check all that apply)

- ☐ No, not Hispanic
- ☐ Yes, Mexican
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, Other Hispanic Origin (**Specify**) **:**_____

What is your race? (Check all that apply)

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
  (Specify tribe): _____
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (Specify):
  _____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander (Specify):
  _____
- ☐ Other (Specify):
  _____

INFORMANT

What is the relationship of the person providing information?

☐ Mother ☐ Father ☐ Other (Specify):_____

Informant Name (if not Mother of Father):

First	Middle	Last	Suffix

Signature:	Date:

Dolly Parton's Imagination Library Free Book Program for Child

I would like my child to receive a free, high quality, age-appropriate book in the mail every month from birth until they turn five years old through Dolly Parton's Imagination Library (DPIL).

I consent to allow the Dollywood Foundation, Inc. to use the information provided herein for the **sole purpose** of receiving books from DPIL. To measure the program's effectiveness DPIL may create datasets with the information provided; however, your full name, date of birth and street address will **not** be released to researchers.

You agree to review our full Terms & Conditions and Privacy Policy by visiting imaginationlibrary.com. By selecting Yes, you expressly consent to the terms set forth herein.

☐ Yes, English – Mostly English books with an occasional bilingual English/Spanish book

☐ Yes, Bilingual English/Spanish – All bilingual English/Spanish books

☐ No

Email Address: _____

FIRELANDSHEALTH
Firelands Regional Medical Center

* S A F E T Y *

PATIENT LABEL

GUIDELINES: GENERAL/SIBLING VISITATION

OB visitation is limited to:

- Labor- 2 **designated** individuals (no swapping) throughout your labor and delivery.
- Postpartum- 1 **designated** overnight visitor to stay throughout your hospitalization.
- Open visitation is allowed in Postpartum ONLY for all other visitors from 10:00 AM-12:00 PM and 5:00 PM-8:30 PM. No other children under the age of 18 permitted visitation, UNLESS SIBLINGS OF THE NEWBORN.

Visiting siblings are to be free of any signs of infection (fever, cough, sneezing, runny nose, rash). They must not have been exposed to communicable illnesses (chickenpox, measles, rubella, mumps, etc.) within the past three (3) weeks.

Nursing staff reserves the right to disallow sibling visitation if there is any reason to suspect infection and/or communicable illness exposure.

Siblings must be accompanied by an adult. Parents shall assume responsibility for the visiting siblings' conduct.

Sibling visitation shall take place in the mother's room following thorough handwashing.

I certify that to the best of my knowledge, my visiting children are free of infection and communicable illness as stated above.

The above information has been reviewed with me. I have had a chance to ask questions which were answered to my satisfaction.

Mother: _____

Witness: _____

Date: _____

FIRELANDSHEALTH
Firelands Regional Medical Center

* S A F E T Y *

PATIENT LABEL

GUIDELINES: INFANT SAFETY

We are so happy you chose Firelands Regional Medical Center for the birth of your baby. During your stay, our goal is to promote family bonding and make this time as safe as possible.

- Your nurse will introduce herself at the beginning of her shift. All maternity staff will wear Birthing Center identification.
- Do not give your baby to **ANYONE** who does not have proper Birthing Center identification. Transport the baby yourself or call your nurse.
- Question unfamiliar persons entering your room or inquiring about your infant, even if they are in hospital clothing or seem to have reason to be there. Alert the nurses station immediately.
- **NEVER LEAVE YOUR INFANT UNSUPERVISED.**
- Never leave the baby alone on your bed.
- Do not take a sleeping pill if you plan to feed the baby during the night or keep the baby in the room.
- Babies will be transported in bassinets - never carried in corridors.
- You, your baby, and the father/support person will receive matching identification bands at the time of birth. These bands will be checked each time you enter the Nursery and each time your baby is brought to your room.

The above information has been reviewed with me. I have had a chance to ask questions which were answered to my satisfaction.

Mother: _____

Witness: _____

Date: _____

FIRELANDSHEALTH
Firelands Regional Medical Center

* C O N S E N T *

PATIENT LABEL

BIRTH ANNOUNCEMENT CONSENT FORM

The birth announcement information will be released to the media upon your consent. The announcement will be given with the patient's names, address, city, son or daughter, and birth date.

1. ☐ If you are married and would like the announcement printed as below, please sign below and fill in the information to be released.

_____
Mother's Signature

2. ☐ If you are a single mother, the announcement will be printed with your name **only** as a parent, **unless** we have both your's and the father's signature below.
Please fill in the information to be released.

_____ _____
Mother's Signature Father's Signature

INFORMATION TO BE RELEASED *(please print)*

Mother's Name: _____ Son or Daughter: _____

Father's Name: _____ City: _____ Birthdate: _____

3. ☐ I **DO NOT** wish to have the birth announcement released to the media.

_____
Mother's Signature

_____ _____ _____
Witness' Signature Title Date

☐ As a Firelands team member, I give permission for the above information to be printed in Firelands publications.

_____ _____ _____
Name of Employee Dept Name of Other Parent (Optional)

_____ _____ _____
Baby's Name Weight Length

FIRELANDSHEALTH
Firelands Regional Medical Center

* S A F E S L *

Patient Label

Patient Access to Safe Sleep Environment Screening

Ohio Department of Health

Signature_____ **Date** _____

Print Name_____

Do you have a safe crib, bassinet, or play yard with a firm mattress for your infant to sleep in after you are discharged from the hospital? (Circle one) Yes or No

---

Please fill out the information below only if you answered "No" to the question above:

Home Zip Code: _____

Delivery Payment: (Circle one)

☐-Medicaid
☐- Other

Race: (Circle all that apply)

☐ - American Indian or Alaska Native
☐ - Asian American
☐ - Black or African American
☐ - Native Hawaiian & Other Pacific Islander
☐ - White
☐ - Unspecified

Ethnicity: (Circle one)

☐ - Hispanic
☐ - Non-Hispanic
☐ - Unspecified

Ohio Law requires facilities to report this information to the Ohio Department of Health upon discharge. A hospital staff member or volunteer will provide more information about safe sleep prior to your discharge.

FOR FACILITY USE ONLY:

Discuss and provide educational information on infant safe sleep per hospital policy.

Parent/Guardian/Other person responsible for infant confirms that a safe crib is available once the infant is discharged from the facility to the infant's residence following birth: Yes or No

Parent/Guardian/Other person does NOT have a crib, bassinet or play yard, check the applicable box below:

☐ Facility provided infant a safe crib using its own resources.

☐ Facility provided infant a safe crib by collaborating with or obtaining assistance from another person or government entity.

☐ Facility referred parent/guardian/other person responsible for infant to a person or government entity to obtain a safe crib.

☐ Facility referred parent/guardian/other person responsible for infant to a site designated by ODH to obtain a safe crib. Use the Cribs for Kids (CFK) partner finder: http://www.cribsforkids.org/find-a-chapter/.

Tdap (Tetanus, Diphtheria, Pertussis) Vaccine: *What You Need to Know*

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

Tdap vaccine can prevent **tetanus, diphtheria**, and **pertussis**.

Diphtheria and pertussis spread from person to person. Tetanus enters the body through cuts or wounds.

- **TETANUS (T)** causes painful stiffening of the muscles. Tetanus can lead to serious health problems, including being unable to open the mouth, having trouble swallowing and breathing, or death.
- **DIPHTHERIA (D)** can lead to difficulty breathing, heart failure, paralysis, or death.
- **PERTUSSIS (aP),** also known as "whooping cough," can cause uncontrollable, violent coughing that makes it hard to breathe, eat, or drink. Pertussis can be extremely serious especially in babies and young children, causing pneumonia, convulsions, brain damage, or death. In teens and adults, it can cause weight loss, loss of bladder control, passing out, and rib fractures from severe coughing.

2. Tdap vaccine

Tdap is only for children 7 years and older, adolescents, and adults.

Adolescents should receive a single dose of Tdap, preferably at age 11 or 12 years.

Pregnant women should get a dose of Tdap during every pregnancy, preferably during the early part of the third trimester, to help protect the newborn from pertussis. Infants are most at risk for severe, life-threatening complications from pertussis.

Adults who have never received Tdap should get a dose of Tdap.

Also, **adults should receive a booster dose of either Tdap or Td** (a different vaccine that protects against tetanus and diphtheria but not pertussis) **every 10 years**, or after 5 years in the case of a severe or dirty wound or burn.

Tdap may be given at the same time as other vaccines.

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of any vaccine that protects against tetanus, diphtheria, or pertussis**, or has any **severe, life-threatening allergies**
- Has had a **coma, decreased level of consciousness, or prolonged seizures within 7 days after a previous dose of any pertussis vaccine (DTP, DTaP, or Tdap)**
- Has **seizures or another nervous system problem**
- Has ever had **Guillain-Barré Syndrome** (also called "GBS")
- Has had **severe pain or swelling after a previous dose of any vaccine that protects against tetanus or diphtheria**

In some cases, your health care provider may decide to postpone Tdap vaccination until a future visit.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting Tdap vaccine.

Your health care provider can give you more information.

CDC U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION

4. Risks of a vaccine reaction

- Pain, redness, or swelling where the shot was given, mild fever, headache, feeling tired, and nausea, vomiting, diarrhea, or stomachache sometimes happen after Tdap vaccination.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

6. The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/vaccines**.

FIRELANDSHEALTH
Firelands Regional Medical Center

* C O N S E N T *

PATIENT LABEL

TETANUS DIPHTHERIA PERTUSSIS (TDAP) VACCINE CONSENT

☐ I have read the Vaccine Information Statement: Tdap Vaccine.

☐ I wish to receive a Tetanus, Diphtheria, Pertussis (Tdap) Vaccine.

☐ I do not wish to receive a Tetanus, Diphtheria, Pertussis (Tdap) Vaccine.

☐ Previously vaccinated this pregnancy

_____ _____

Patient Signature Date

*Return this consent to your nurse to receive a vaccine before discharge.

VACCINE INFORMATION STATEMENT

Hepatitis B Vaccine:
What You Need to Know

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

Hepatitis B vaccine can prevent **hepatitis B**. Hepatitis B is a liver disease that can cause mild illness lasting a few weeks, or it can lead to a serious, lifelong illness.

- **Acute hepatitis B** is a short-term illness that can lead to fever, fatigue, loss of appetite, nausea, vomiting, jaundice (yellow skin or eyes, dark urine, clay-colored bowel movements), and pain in the muscles, joints, and stomach.
- **Chronic hepatitis B** is a long-term illness that occurs when the hepatitis B virus remains in a person's body. Most people who go on to develop chronic hepatitis B do not have symptoms, but it is still very serious and can lead to liver damage (cirrhosis), liver cancer, and death. Chronically infected people can spread hepatitis B virus to others, even if they do not feel or look sick themselves.

Hepatitis B is spread when blood, semen, or other body fluid infected with the hepatitis B virus enters the body of a person who is not infected. People can become infected through:

- Birth (if a pregnant woman has hepatitis B, her baby can become infected)
- Sharing items such as razors or toothbrushes with an infected person
- Contact with the blood or open sores of an infected person
- Sex with an infected partner
- Sharing needles, syringes, or other drug-injection equipment
- Exposure to blood from needlesticks or other sharp instruments

Most people who are vaccinated with hepatitis B vaccine are immune for life.

2. Hepatitis B vaccine

Hepatitis B vaccine is usually given as 2, 3, or 4 shots.

Infants should get their first dose of hepatitis B vaccine at birth and will usually complete the series at 6–18 months of age. **The birth dose of hepatitis B vaccine is an important part of preventing long-term illness in infants and the spread of hepatitis B in the United States.**

Anyone **59 years of age or younger** who has not yet gotten the vaccine should be vaccinated.

Hepatitis B vaccination is recommended for **adults 60 years or older** at increased risk of exposure to hepatitis B who were not vaccinated previously. **Adults 60 years or older** who are not at increased risk and were not vaccinated in the past may also be vaccinated.

Hepatitis B vaccine may be given as a stand-alone vaccine, or as part of a combination vaccine (a type of vaccine that combines more than one vaccine together into one shot).

Hepatitis B vaccine may be given at the same time as other vaccines.

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of hepatitis B vaccine**, or has any **severe, life-threatening allergies**

In some cases, your health care provider may decide to postpone hepatitis B vaccination until a future visit.

LP-8988 Rev.10/14/25

CDC U.S. CENTERS FOR DISEASE CONTROL AND PREVENTION

Pregnant or breastfeeding women who were not vaccinated previously should be vaccinated. Pregnancy or breastfeeding are not reasons to avoid hepatitis B vaccination.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting hepatitis B vaccine.

Your health care provider can give you more information.

4. Risks of a vaccine reaction

- Soreness where the shot is given, fever, headache, and fatigue (feeling tired) can happen after hepatitis B vaccination.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at **www.vaers.hhs.gov** or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

6. The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at **www.hrsa.gov/vaccinecompensation** or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at **www.fda.gov/vaccines-blood-biologics/vaccines**
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at **www.cdc.gov/vaccines**.

FIRELANDSHEALTH
Firelands Regional Medical Center

* C O N S E N T *

Patient Label

NEWBORN NURSERY
HEPATITIS B REQUEST SLIP

Physicians generally recommend this vaccine for most newborns. After reading the attached information flyer, please discuss any questions or concerns with your pediatrician or family doctor.

☐ **YES,** I wish for my baby to receive this vaccine before his/her discharge from the nursery.

_____ _____
Mother's/Guardian Signature Date

Please return this slip to your nurse. You may keep the information sheet.

Child's Hepatitis B Vaccine (HBV)

Immunization __ __ __ __ __ __ __ __
M M D D Y Y Y Y

Date _____

_____
Brand (Manufacturer)

Lot # _____

VIS edition date _____

Child's Hepatitis B Immune Globulin (HBIG)

Immunization __ __ __ __ __ __ __ __
M M D D Y Y Y Y

Date _____

_____
Brand (Manufacturer)

Lot # _____

☐ **NO,** I do not want my baby to receive this vaccine in the nursery.

_____ _____
Mother's/Guardian Signature Date

LP-8988 Rev.10/14/25