Services de santé du TIMISKAMING Health Unit

SCHOOL IMMUNIZATION CONSENT (Gr. 7)

1. STUDENT INFORMATION (please print)

Legal Last Name				Legal First Name		○ Male	○ Female	○ Other
Birthday Year	Month	Day	School			Class or Teacher's Name		
Parent / Legal Guardian Name			Relationship to Student		Home Phone:	Work or Cell:		

2. STUDENT IMMUNIZATION

My child has **already received** the following: *(circle trade name & provide dates vaccines were given)*

○ hepatitis B vaccine
Engerix®-B / Recombivax-HB®

dates: ____________ yyyy/mm/dd ____________ yyyy/mm/dd ____________ yyyy/mm/dd

○ meningococcal-ACYW-135 vaccine
Menactra®/ Menveo™/ Nimenrix®

date: ____________ yyyy/mm/dd

○ combination hepatitis A & B vaccine
Twinrix® Jr. / Twinrix®

dates: ____________ yyyy/mm/dd ____________ yyyy/mm/dd ____________ yyyy/mm/dd

○ human papillomavirus vaccine
Gardasil® / Gardasil®9 / Cervarix®

dates: ____________ yyyy/mm/dd ____________ yyyy/mm/dd ____________ yyyy/mm/dd

3. STUDENT HEALTH HISTORY

	Question		If "yes," explain
a)	Is your child allergic to yeast, alum, latex, diphtheria toxoid protein, other?	○ Yes ○ No	
b)	Has your child ever had a reaction to a vaccine?	○ Yes ○ No	
c)	Does your child have a history of fainting?	○ Yes ○ No	
d)	Does your child have a serious medical condition?	○ Yes ○ No	
e)	Does your child have a weak immune system or taking a medication that increases the risk of infection? (e.g. corticosteroids)	○ Yes ○ No	

4. CONSENT FOR VACCINATION

I have read the attached immunization vaccine fact sheets. I understand the expected benefits and possible risks and side effects of the vaccines. I understand the possible risks to my child if not vaccinated. I have had the opportunity to have my questions answered by the Timiskaming Health Unit. This consent is valid for two years. I understand that I can withdraw my consent at any time. I understand that my child may receive up to three injections on the same day.

INDICATE YOUR CONSENT BY SELECTING YES OR NO FOR EACH VACCINE AND SIGN:

☐ **YES**	I authorize the Timiskaming Health Unit to administer **one dose of meningococcal-ACYW-135* vaccine** to my child.
☐ **NO**	I do not authorize the Timiskaming Health Unit to vaccinate my child with meningococcal* vaccine. *This vaccine is required for school attendance.
☐ **YES**	I authorize the Timiskaming Health Unit to administer **two doses of human papillomavirus vaccine (Gardasil®9)** to my child to be given at least six months apart.
☐ **NO**	I do not authorize Timiskaming Health Unit to vaccinate my child with human papillomavirus vaccine.
☐ **YES**	I authorize the Timiskaming Health Unit to administer **two doses of hepatitis B vaccine** to my child to be given at least six months apart.
☐ **NO**	I do not authorize the Timiskaming Health Unit to vaccinate my child with hepatitis B vaccine.

X ______________________________ ____________________

Signature of Parent ☐ **or Legal Guardian** ☐ **Date**

Please return the signed consent to the school within 2 (two) days of receiving.

The information provided or attached to this form is being collected, and will be used by, Timiskaming Health Unit (THU) for the purpose of the Medical Officer of Health maintaining an immunization record on the above named student and to take appropriate action to prevent certain vaccine preventable diseases. THU will enter your child's immunization information into a secure provincial immunization database called Panorama. Your child's immunization information may be shared with or accessed by another health care provider for the purpose of providing care to you or your dependent, and otherwise as required or permitted by law. If you do not want this information shared please provide notification to the address provided. If you have questions about the privacy of your child's immunization information, please contact us at 43-247 Whitewood Avenue P.O Box 1090 New Liskeard, ON P0J 1P0.

TIMISKAMING HEALTH UNIT USE ONLY (Checklist to assist with assessment. Use vaccine administration section only if unable to record in Panorama)

1. **Use 2 client identifiers**
2. **HPV 2-dose schedule**: is there a minimum of 168 days since dose one?
3. **Hepatitis B 2-dose schedule**: is there a minimum of 168 days since dose one?
4. Has student received hepatitis B, HPV or meningococcal vaccine from another health care provider?
5. Does student understand what the vaccine(s) are for?
6. Does student verify if they have ever had a reaction to a vaccine? .
7. Inquire if student has any allergies.
8. Inquire if anything changed with students health recently.
9. Inquire if student has a fever today.
10. Inquire if student thinks they might be pregnant?

MENINGOCOCCAL-ACYW-135 VACCINE (Menactra®)

○ **Menactra® 0.5 mL**

○ **Menveo™ 0.5 mL**

○ **Nimenrix® 0.5 mL**

TIME ______________________

DATE ______________________

IM DELTOID: Left Right

LOT # ______________________

SIGNATURE: ______________________

Panorama entered by:

HUMAN PAPILLOMAVIRUS VACCINE (Gardasil®9)

○ **Dose 1: 0.5 mL**

DATE ______________________

TIME ______________________

LOT # ______________________

IM DELTOID: Left Right

SIGNATURE: ______________________

Panorama entered by:

○ **Dose 2: 0.5 mL**

DATE ______________________

TIME ______________________

LOT # ______________________

IM DELTOID: Left Right

SIGNATURE: ______________________

Panorama entered by:

HEPATITIS B VACCINE

Dose 1

○ **Engerix®-B 1.0mL / 0.5mL IM**

○ **Recombivax HB® 1.0mL / 0.5mL IM**

DATE ______________________

TIME ______________________

LOT # ______________________

DELTOID: Left Right

SIGNATURE: ______________________

Panorama entered by:

Dose 2

○ **Engerix®-B 1.0mL / 0.5mL IM**

○ **Recombivax HB® 1.0mL / 0.5mL IM**

DATE ______________________

TIME ______________________

LOT # ______________________

DELTOID: Left Right

SIGNATURE: ______________________

Panorama entered by:

NOTES