Services de santé du TIMISKAMING Health Unit

GRADE 7 SCHOOL IMMUNIZATION PROGRAM CONSENT FORM

Porcupine Health Unit • Bureau de santé

1. PERSONAL INFORMATION (as per Health Card)

Legal Last Name	Legal First Name	Gender
Date of Birth Year Month Day	Preferred Name (if different than Health Card)	Health Care Provider
School	Teacher or Class	Caregiver Email
Caregiver Name (Please Print)	Relationship to Student	Home Phone/Cell / Work/Other Phone

2. STUDENT HEALTH HISTORY

	CHECK ONE	IF YES, PLEASE EXPLAIN
Does your child have any allergies?	◯ YES ◯ NO	
Has your child ever had a reaction to a vaccine?	◯ YES ◯ NO	
Does your child have a history of fainting or seizures?	◯ YES ◯ NO	
Does your child have a serious medical condition?	◯ YES ◯ NO	
Does your child have a weak immune system or take any medications?	◯ YES ◯ NO	

3. STUDENT IMMUNIZATION HISTORY

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

◯ Hepatitis B vaccine (Engerix®-B / Recombivax-HB®)
Dates: yyyy/mm/dd yyyy/mm/dd yyyy/mm/dd

◯ Meningococcal A,C,Y,W-135 vaccine (Menactra® / Menveo™ / Nimenrix®)
Date: yyyy/mm/dd

◯ Hepatitis A & B vaccine (Twinrix® Jr. / Twinrix®)
Dates: yyyy/mm/dd yyyy/mm/dd yyyy/mm/dd

◯ Human Papillomavirus vaccine (Gardasil® / Cervarix®)
Dates: yyyy/mm/dd yyyy/mm/dd yyyy/mm/dd

4. CONSENT FOR IMMUNIZATION

I have read the immunization information sheet and I understand the 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 my local public health unit. This consent is valid until the end of Grade 8. 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.

CHECK ✓ THE BOXES BELOW, INDICATING YOUR CONSENT FOR EACH VACCINE

Meningococcal Quadrivalent Vaccine (1 dose) – REQUIRED FOR SCHOOL

◯ YES, I authorize my local health unit to administer **1 dose** of Meningococcal ACYW-135 vaccine to my child.

◯ NO, I DO NOT CONSENT

**I understand the possible consequences if my child is not vaccinated against Meningococcal disease. An education session and exemption form are required. The form must be notarized and filed at your local health unit.*

Human Papillomavirus Vaccine (2 doses)

◯ YES, I authorize my local health unit to administer **2 doses** of Human Papillomavirus vaccine to my child.

◯ NO, I DO NOT CONSENT

Hepatitis B Vaccine (2 doses)

◯ YES, I authorize my local health unit to administer **2 doses** of Hepatitis B vaccine to my child.

◯ NO, I DO NOT CONSENT

SIGNATURE OF STUDENT/PARENT/LEGAL GUARDIAN (REQUIRED)

Signature: _____ Print Name: _____ Date: yyyy/mm/dd

HEALTH UNIT USE ONLY

FOR HEALTH UNIT USE ONLY (only required to document verbal consent)

Verbal consent obtained from client's *(relationship to student)*, *(person"s full name)*, on *(yyyy/mm/dd)*

at (time) by *(name of person obtaining consent)*. Signature: _____

Student Name	Date of Birth			
NURSE TO COMPLETE	**DOSE 1**		**DOSE 2**	
1. HPV: Is there a minimum of 6 months since dose one?	Not applicable		◯ Yes	◯ No
2. Hepatitis B: Is there a minimum of 6 months since dose one?	Not applicable		◯ Yes	◯ No
3. Have you received a vaccine recently?	◯ Yes	◯ No	◯ Yes	◯ No
4. Do you understand what the vaccine(s) are for?	◯ Yes	◯ No	◯ Yes	◯ No
5. Are you feeling well/have you had a fever recently?	◯ Yes	◯ No	◯ Yes	◯ No
6. Do you think you might be pregnant? N/A ◯	◯ Yes	◯ No	◯ Yes	◯ No
7. Students' health history reviewed?	◯ Yes	◯ No	◯ Yes	◯ No
8. Have there been any changes to your health since consent was received?	◯ Yes	◯ No	◯ Yes	◯ No
9. Which card did you select today?	C, A, R, D		C, A, R, D	
	Nurses Initials		Nurses Initials	

VACCINE PREPARATION, ADMINISTRATION AND DOCUMENTATION

Complete your 3 vaccine checks: as you select the vaccine, as you draw it up, and just before administration.

Meningococcal (Men C-ACYW135) Vaccine (1 dose)

◯ Menactra® 0.5ml IM ◯ Menveo™ 0.5ml IM ◯ Nimenrix® 0.5ml IM (select vaccine given)

DOSE	3 VACCINE CHECKS	DATE	TIME	LOT # & EXPIRY	DELTOID SITE		NURSE SIGNATURE	DATA ENTERED
1	Y/N				R	L		Y/N

Human Papillomavirus (HPV-9) Vaccine (2 doses)

◯ Gardasil®9 0.5ml IM

DOSE	3 VACCINE CHECKS	DATE	TIME	LOT # & EXPIRY	DELTOID SITE		NURSE SIGNATURE	DATA ENTERED
1	Y/N				R	L		Y/N
2	Y/N				R	L		Y/N

Hepatitis B Vaccine (2 doses)

◯ Engerix-B® 1.0ml ◯ Recombivax-HB® 1.0ml (select vaccine given)

DOSE	3 VACCINE CHECKS	DATE	TIME	LOT # & EXPIRY	DELTOID SITE		NURSE SIGNATURE	DATA ENTERED
1	Y/N				R	L		Y/N
2	Y/N				R	L		Y/N

PROGRESS NOTES

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