Meningococcal ACYW-135 Hepatitis B & Human Papillomavirus Vaccines

Consent Form

Part 1 Student Information

LAST NAME	FIRST NAME	GENDER

DATE OF BIRTH	ONTARIO HEALTH CARD (optional)	SCHOOL	CLASS RM OR TEACHER

PARENT / LEGAL GUARDIAN LAST & FIRST NAME	RELATION TO STUDENT

HOME ADDRESS	CITY	POSTAL CODE

HOME PHONE NUMBER	WORK PHONE NUMBER	CELLPHONE NUMBER

Part 2 Student Health History

Answer the four questions in regards to your child's health history. If you answer "yes" to one of them, briefly describe.		**If yes, briefly describe.**
1. Does the student have a serious medical condition?	○ Yes ○ No	
2. Has the student ever had a reaction(s) to any vaccines?	○ Yes ○ No	
3. Does the student have a history of fainting?	○ Yes ○ No	
4. Does the student have any allergies?	○ Yes ○ No	

Part 3 Student Immunization History

The **Meningococcal ACYW-135** vaccine is not the same vaccine that your child received at 1 year of age. This vaccine is required for school and must be given after the 12th birthday or in grade 7. Your child may not require Hepatitis B and/or Human Papillomavirus vaccines if they have received them in the past. If your child has received any of the above mentioned vaccines, it is important for the Nurse to know. **<u>Fill in the spaces below</u> <u>or attach a copy of your child's immunization record to this consent</u>**. The Nurse needs this information in order to assess your child's immunization history.

If your child has NOT received any of those vaccines in the past, please proceed to Part 4.

Vaccine	Product	Dates
Meningococcal ACYW-135 This vaccine is **required** for school and must be given **after the 12th birthday or in grade 7.**	○ Menactra® ○ Nimenrix® ○ Menveo®	**Single dose:** YYYY/MM/DD
Hepatitis B	○ Engerix® ○ Twinrix® ○ Recombivax® ○ Twinrix Jr®	**Dose 1:** YYYY/MM/DD **Dose 2:** YYYY/MM/DD **Dose 3:** YYYY/MM/DD
Human Papillomavirus	○ Gardasil® ○ Cervarix®	**Dose 1:** YYYY/MM/DD **Dose 2:** YYYY/MM/DD **Dose 3:** YYYY/MM/DD

Part 4 Consent for immunization

I have read the attached vaccine fact sheets. I understand the expected benefits and possible side effects of the vaccines as well as the possible risks to my child and others if not vaccinated. I have had the opportunity to have my questions answered by Renfrew County and District Health Unit (RCDHU).

Please check YES or NO for each of the following vaccines listed:	I **<u>authorize</u>** RCDHU to immunize my child.	I **<u>do not authorize</u>** RCDHU to immunize my child.
Meningococcal ACYW-135 **This vaccine is **required** for all students to attend school (Immunization of School Pupils Act).**	○ **YES**	○ **NO**
Hepatitis B This vaccine requires a two dose series, separated by 4 to 6 months.	○ **YES**	○ **NO**
Human Papillomavirus This vaccine requires a two dose series separated by six months or a three dose series.	○ **YES**	○ **NO**

Parent/legal guardian signature is recommended although there is no minimum age for giving consent to health care in Ontario.
By signing below, I acknowledge and declare that the information provided in this consent form is true and accurate.

PRINTED NAME	SIGNATURE	DATE (YYYY/MM/DD)

To contact us or for more information:

613-735-8653 or 1-800-267-1097

www.rcdhu.com
Healthy Living
Immunization
Gr 7 Immunizations

7 International Dr Pembroke, ON K8A 6W5

@RCDHealthunit

Personal information contained on this form is collected under the authority of one or more of the following (as amended): the Health Protection and Promotion Act, R.S.O. 1990; the Immunization of School Pupils Act, R.S.O. 1990; the Regulated Health Professions Act, 1991, S.O. 1991; and is in compliance with the Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990 and the Personal Health Information Protection Act, 2004, S.O. 2004. This information is used to ensure that all appropriate personal care and public health services are provided, and that necessary statistics are kept. Questions about this collection should be directed to the Program Manager at the Renfrew County and District Health Unit, 7 International Drive, Pembroke, ON K8A 6W5, 613-735-8651.

Student's name: ______________________________ DOB: ______________

MENINGOCOCCAL-ACYW-135 VACCINE (Menactra®)

Dose 1: 0.5 mL

DATE: ______________________ LOT # : ______________________

TIME: ______________________ SIGNATURE: ______________________

IM DELTOID: Left Right PANORAMA ENTERED BY: ______________

HEPATITIS B VACCINE

Dose 1: 0.5 mL

○ Engerix®-B 1.0mL / 0.5mL IM

○ Recombivax HB® 1.0mL / 0.5mL IM

DATE: ______________________

TIME: ______________________

LOT # : ______________________

IM DELTOID: Left Right

SIGNATURE: ______________________

PANORAMA ENTERED BY: ______________

Dose 2: 0.5 mL

○ Engerix®-B 1.0mL / 0.5mL IM

○ Recombivax HB® 1.0mL / 0.5mL IM

DATE: ______________________

TIME: ______________________

LOT # : ______________________

IM DELTOID: Left Right

SIGNATURE: ______________________

PANORAMA ENTERED BY: ______________

HUMAN PAPILLOMAVIRUS VACCINE (Gardasil®)

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: __________

Dose 3 (if required): **0.5 mL**

DATE: ______________________

TIME: ______________________

LOT # : ______________________

IM DELTOID: Left Right

SIGNATURE: ______________________

PANORAMA ENTERED BY: __________

Nurse's Notes

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