Meningococcal ACYW-135, Hepatitis B & Human Papillomavirus Vaccines
Renfrew County and District Health Unit (RCDHU) Consent Form

Renfrew County and District Health Unit

Part 1 Student Information

LAST NAME	FIRST NAME	GENDER

DATE OF BIRTH YYYY/MM/DD	ONTARIO HEALTH CARD	SCHOOL	CLASS RM OR TEACHER

STREET ADDRESS	CITY	POSTAL CODE

Part 2 Student Health History

Answer the four questions concerning 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.
- Your child may not require Hepatitis B and/or Human Papillomavirus vaccines if they received them in the past.
- If your child has received any of the above mentioned vaccines **fill in the spaces below or attach a copy of your child's immunization record to this consent**.
- **If your child has NOT received any of those vaccines in the past, please proceed to Part 4.**

Meningococcal ACYW-135	○ Menactra® ○ Nimemrix®	○ 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 pamphlet. 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.

Please check YES or NO for each of the following vaccines listed:	I **authorize** RCDHU to immunize my child.	I **do not authorize** RCDHU to immunize my child.	*For Nurse's purposes only.*	*Nurse's Initials*
Meningococcal ACYW-135 This vaccine is **required** for all students to attend school.	○ **YES**	○ **NO**	**Single dose:** YYYY/MM/DD	_____
Hepatitis B (A two or three dose series)	○ **YES**	○ **NO**	**Dose 1:** YYYY/MM/DD **Dose 2:** YYYY/MM/DD **Dose 3:** YYYY/MM/DD	_____ _____ _____
Human Papillomavirus (A two or three dose series)	○ **YES**	○ **NO**	**Dose 1:** YYYY/MM/DD **Dose 2:** YYYY/MM/DD **Dose 3:** YYYY/MM/DD	_____ _____ _____

Part 5 Required Parent/Legal Guardian Information

PRINTED NAME OF PARENT/LEGAL GUARDIAN	RELATIONSHIP TO STUDENT

HOME PHONE NUMBER	WORK PHONE NUMBER	CELLPHONE NUMBER

SIGNATURE	DATE YYYY/MM/DD

By signing above, I acknowledge and declare that the information provided in this consent form is true and accurate.

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.