MENINGOCOCCAL ACYW-135, HEPATITIS B AND HUMAN PAPILLOMAVIRUS VACCINES GR 9-10 RENFREW COUNTY AND DISTRICT HEALTH UNIT (RCDHU) CONSENT FORM

PART 1	STUDENT INFORMATION		
LAST NAME	FIRST NAME	DATE OF BIRTH YYYY/MM/DD	GENDER
ONTARIO HEALTH CARD *(required to identify student)*	SCHOOL NAME AND GRADE		CLASS RM OR TEACHER
STREET ADDRESS	CITY		POSTAL CODE

PART 2	STUDENT HEALTH HISTORY	
Answer the four questions concerning your youth's health history.		**If you answered 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 youth received at 1 year of age.
- Your youth may not require Hepatitis B and/or Human Papillomavirus vaccines if they received them in the past. Two or three doses of Hepatitis B (HB) and Human Papillomavirus (HPV) vaccine is needed to be fully protected.
- If your youth has received doses of the vaccines mentioned above by a health care provider, update with us online through the ICON page located on our website or complete the section below by indicating when they received these vaccines.
- **If your youth requires a dose of Meningococcal ACYW-135 vaccine OR any doses for HB/HPV vaccine(s),**

Vaccine	Product		Dates
Meningococcal ACYW-135	○ 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 electronic letter and pamphlet fact sheets. I understand the expected benefits and possible side effects of the vaccines as well as the possible risks to my youth and others if not vaccinated. Consent is applied until the two-or three dose series for Hepatitis B and Human Papillomavirus is complete.

Please check YES or NO for each of the following vaccines listed:	I **DO authorize** RCDHU to immunize my youth.	I **do not authorize** RCDHU to immunize my youth.	*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 Renfrew County and District Health Unit, at 141 Lake Street, Pembroke ON K8A 5L8 1-613-732-3629.