



Meningococcal ACYW-135, Hepatitis B & Human Papillomavirus Vaccines

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 <i>(required to identify student)</i>		SCHOOL NAME AND GRADE	CLASS RM OR TEACHER
STREET ADDRESS		CITY	POSTAL CODE

Part 2 Student Health History		
Answer the five questions concerning your child's health history.		If you answered yes, briefly describe.
1. Does the student have a serious medical condition?	<input type="radio"/> Yes <input type="radio"/> No	
2. Has the student ever had a reaction(s) to any vaccines?	<input type="radio"/> Yes <input type="radio"/> No	
3. Has this student received one or two doses of COVID-19 vaccine recently?	<input type="radio"/> Yes <input type="radio"/> No	Date Dose #1: YYYY/MM/DD Date Dose #2: YYYY/MM/DD
4. Does the student have a history of fainting?	<input type="radio"/> Yes <input type="radio"/> No	
5. Does the student have any allergies?	<input type="radio"/> Yes <input type="radio"/> No	

Part 3 Student Immunization History		
<ul style="list-style-type: none"> 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	<input type="radio"/> Menactra® <input type="radio"/> Menveo® <input type="radio"/> Nimenrix®	Single dose: YYYY/MM/DD
Hepatitis B	<input type="radio"/> Engerix® <input type="radio"/> Recombivax® <input type="radio"/> Twinrix® <input type="radio"/> Twinrix Jr®	Dose 1: YYYY/MM/DD Dose 2: YYYY/MM/DD Dose 3: YYYY/MM/DD
Human Papillomavirus	<input type="radio"/> Gardasil® <input type="radio"/> 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 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 child and others if not vaccinated. Consent is applied until the two-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 child.	I do not authorize RCDHU to immunize my child.	<i>For Nurse's purposes only.</i>	<i>Nurse's Initials</i>
Meningococcal ACYW-135 This vaccine is required for all students to attend school.	<input type="radio"/> YES	<input type="radio"/> NO	Single dose: YYYY/MM/DD	_____
Hepatitis B (A two or three dose series)	<input type="radio"/> YES	<input type="radio"/> NO	Dose 1: YYYY/MM/DD Dose 2: YYYY/MM/DD Dose 3: YYYY/MM/DD	_____ _____ _____
Human Papillomavirus (A two or three dose series)	<input type="radio"/> YES	<input type="radio"/> 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, at 141 Lake Street, Pembroke ON K8A 5L8 1-613-732-9436.