



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 <small>YYYY/MM/DD</small>	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 four questions concerning your youth'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. Does the student have a history of fainting?	<input type="radio"/> Yes <input type="radio"/> No	
4. 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 <u>not</u> 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 <u>OR</u> any doses for HB/HPV vaccine(s), 		
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 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.	<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 Renfrew County and District Health Unit, at 141 Lake Street, Pembroke ON K8A 5L8 1-613-732-9436.