Renfrew County and District Health Unit
"Optimal Health for All in Renfrew County and District"

Grade 7 School Immunization Program Consent Form

MENINGOCOCCAL ACYW-135, HEPATITIS B & HUMAN PAPILLOMAVIRUS VACCINES

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 child's health history.			**If you answered YES, briefly describe.**
1. Does your child have a serious medical condition?	○ YES	○ NO	
2. Has your child ever had a reaction(s) to any vaccines?	○ YES	○ NO	
3. Does your child have a history of fainting?	○ YES	○ NO	
4. Does your child 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 one year of age.
- Your child may not require Hepatitis B and/or Human Papillomavirus vaccine(s) if already received.
- Has your child received any of these vaccines before? If yes, complete the section below by indicating the date they received these vaccines.
- Update your child's immunization record by using the ICON tool via www.rcdhu.com, by emailing a copy to schoolimmunization@rcdhu.com or by attaching a printed copy to this form.
- **If your child has NOT received any of these vaccines in the past or is missing a dose, please proceed to Part 4.**

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 acknowledge and declare that the information provided in this consent form is true and accurate. I have read the attached parent/legal guardian letter and info fact sheet. 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. **Of note, for Hepatitis B and Human Papillomavirus vaccines, the consent is applied until the two-dose series 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.	***For Nurse's Use ONLY***	
			Date Dose Given	**Nurse's Initials**
Meningococcal ACYW-135 (**Required** for all students to attend school)	○ **YES**	○ **NO**	**Single Dose:** YYYY/MM/DD	_____
Hepatitis B (A two dose series)	○ **YES**	○ **NO**	**Dose 1:** YYYY/MM/DD **Dose 2:** YYYY/MM/DD	_____ _____
Human Papillomavirus (A two dose series)	○ **YES**	○ **NO**	**Dose 1:** YYYY/MM/DD **Dose 2**: YYYY/MM/DD	_____ _____

PART 5 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	

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 1-613-732-3629.