Huron Perth Public Health

School Immunization Consent Form

Meningococcal A,C,Y,W-135 | Hepatitis B and Human Papillomavirus (HPV9)

Use this form to request consent for receiving school-based immunizations.

Student personal information

(Please print)

1

Last Name _____ Preferred First Name _____ Gender _____

Legal First Name _____ Preferred Pronoun _____ Date of Birth _____

Address _____

School _____ Teacher's Name _____

Healthcare Provider Name _____ Healthcare Provider Phone _____

Student health history

Health history reviewed:

Dose #1: _____

Dose # 2: _____

(nurse's initial)

2

			If yes, please explain:
Does your child have any allergies? Please review fact sheet.	Yes ☐	No ☐	
Has your child ever had a serious reaction to a vaccine?	Yes ☐	No ☐	
Does your child have a history of fainting, asthma or seizures?	Yes ☐	No ☐	
Does your child have a serious medical condition(s)?	Yes ☐	No ☐	
Does your child take any medications?	Yes ☐	No ☐	
Is your child pregnant?	Yes ☐	No ☐	

Student immunization history

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My child has already received the following *(circle trade name and provide dates vaccines were given).*

☐ **Hepatitis B vaccine**
Engerix-B | Recombivax-HB

Dates: _____ *(yyyy/mm/dd)* _____ *(yyyy/mm/dd)* _____ *(yyyy/mm/dd)*

☐ **Hepatitis A & B combination vaccine**
Twinrix Jr. | Twinrix

Dates: _____ *(yyyy/mm/dd)* _____ *(yyyy/mm/dd)* _____ *(yyyy/mm/dd)*

☐ **Meningococcal A,C,Y,W-135 vaccine**
Menactra | Menveo | Nimenrix

Date: _____ *(yyyy/mm/dd)* *(Do NOT include Menjugate | NeisVac-C)*

☐ **Human Papillomavirus vaccine**
Gardasil |Cervarix| Gardasil-9

Dates: _____ *(yyyy/mm/dd)* _____ *(yyyy/mm/dd)* _____ *(yyyy/mm/dd)*

Consent for immunization

I have read the immunization information fact sheets and understand the benefits and possible risks and side effects of the vaccines. I understand the possible risks to my child if **NOT** vaccinated.

I have had the opportunity to have my questions answered by Huron Perth Public Health. **This consent is valid until the vaccine series is completed.**

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Meningococcal Quadrivalent Vaccine (1 dose) - REQUIRED FOR SCHOOL

☐ YES, I authorize Huron Perth Public Health to administer 1 dose of Meningococcal A,C,Y,W-135 vaccine to my child.

☐ NO, I DO NOT CONSENT
I understand the possible consequences if my child is not vaccinated against meningococcal disease. An education session and exemption form is required and must be commissioned and filed with public health.

Hepatitis B Vaccine (2 doses)

☐ YES, I authorize Huron Perth Public Health to administer 2 doses of Hepatitis B vaccine to my child.

☐ NO, I DO NOT CONSENT

Human Papillomavirus (HPV-9) Vaccine (2 doses)

☐ YES, I authorize Huron Perth Public Health to administer 2 doses of Human Papillomavirus vaccine to my child.

☐ NO, I DO NOT CONSENT

Signature

Required

5

Parent/Guardian Signature ***(required)***

X _____

Date *(yyyy/mm/dd)* _____

Relationship to student _____

Please print name _____

Daytime phone # _____

Unless cancelled, this request is valid for the time period required to complete the vaccine series. This information is collected under the authority of the ***Health Protection and Promotion Act*** and the ***Immunization of School Pupils Act*** for the purpose of maintaining an immunization record for this student. For more information, contact **HPPH** at **1-888-221-2133**.

Student information

1

Student's Name _____ Teacher's Name _____

Vaccine information for Health Unit use only

To be completed by nurse

2

Meningococcal Quadrivalent Vaccine

Menactra | 0.5mL IM Menveo | 0.5mL IM Nimenrix | 0.5mL IM

Date	Time	Vaccine Name | Lot #	Deltoid Site		Initials	Data Entered ✓
			L	R		

Hepatitis B Vaccine (2 doses)

Engerix-B | 1.0mL IM (E) Recombivax-HB | 1.0mL IM (R)

Dose	Date	Time	Vaccine Name | Lot #	Deltoid Site		Initials	Data Entered ✓
1				L	R		
2				L	R		

Human Papillomavirus (HPV-9) Vaccine (2 doses)

Gardasil-9 | 0.5mL IM

Dose	Date	Time	Vaccine Name | Lot #	Deltoid Site		Initials	Data Entered ✓
1				L	R		
2				L	R		

Nurse's notes

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