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

First Name ____________ Last Name ____________

Preferred Name ____________ Preferred Pronoun ____________ Gender ____________

Address ____________ Postal Code ____________

Date of Birth ____________ Ontario Health Card # ____________

School ____________ Teacher's Name ____________

Parent/Guardian Name ____________ Relationship to Student ____________

Home/Cell Phone ____________ Work Phone ____________

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 which may affect their immune system*?	Yes	No	
*Confirm your specialist agrees this is the right time for your child to receive these vaccines?	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 notarized and filed at 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

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

X

Date *(yyyy/mm/dd)* ____________

Please Print Name ____________

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	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	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	Lot #	Deltoid Site		Initials	Data Entered ✓
1				L	R		
2				L	R		

Nurse's notes

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