

SCHOOL IMMUNIZATION CONSENT FORM

1. STUDENT PERSONAL INFORMATION

Last Name			First Name			Preferred Name			
Preferred Pronoun			Gender			Ontario Health Card #			
Date of Birth				School			Teacher's Name		
Year		Month		Day					
Parent/Guardian Name (please print)			Relationship to Student			Home Phone/Cell		Work	
Health Care Provider Name						Health Care Provider Phone			

2. STUDENT HEALTH HISTORY

CHECK ONE

IF YES, PLEASE EXPLAIN

Does your child have any allergies?	<input type="radio"/> YES <input type="radio"/> NO	
Has your child ever had a reaction to a vaccine?	<input type="radio"/> YES <input type="radio"/> NO	
Does your child have a history of fainting or seizures?	<input type="radio"/> YES <input type="radio"/> NO	
Does your child have a serious medical condition?	<input type="radio"/> YES <input type="radio"/> NO	

3. STUDENT IMMUNIZATION HISTORY

My child has already received the following (circle trade names and provide dates vaccines were given):

<input type="radio"/> Hepatitis B vaccine Engerix [®] -B / Recombivax-HB [®] Dates: _____ _____ / _____ / _____	<input type="radio"/> Meningococcal A,C,Y,W-135 vaccine Menactra [®] / Menveo [™] / Nimenrix [®] <small>(Do NOT include Men-C-C vaccines - eg. Menjugate[®], NeisVac-C[®])</small> Date: _____ _____ / _____
<input type="radio"/> Combination Hepatitis A & B vaccine Twinrix [®] Jr. / Twinrix [®] Dates: _____ _____ / _____ / _____	<input type="radio"/> Human Papillomavirus vaccine Gardasil [®] / Cervarix [®] / Gardasil [®] 9 Dates: _____ _____ / _____ / _____

4. CONSENT FOR IMMUNIZATION

I have read the immunization information sheet and I 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 Southwestern Public Health. This consent is valid until the vaccine series is completed or until the end of grade 8.

Please check Yes or No for each of the vaccines:

Meningococcal Quadrivalent Vaccine (1 dose) - REQUIRED FOR SCHOOL

- YES, I authorize Southwestern Public Health to administer 1 dose of Meningococcal ACYW-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.*

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

- YES, I authorize Southwestern Public Health to administer 2 doses of Human Papillomavirus vaccine to my child
- NO, I DO NOT CONSENT

Hepatitis B Vaccine (2 doses)

- YES, I authorize Southwestern Public Health to administer 2 doses of Hepatitis B vaccine to my child
- NO, I DO NOT CONSENT

SIGNATURE REQUIRED

Signature: _____ Print Name: _____ Date: _____
Parent/Guardian Parent/Guardian

STUDENT NAME

TEACHER

VACCINE INFORMATION (Use only in the event of a mIMMS or Panorama failure.)**Meningococcal Quadrivalent Vaccine** Menactra® 0.5ml IM Menveo™ 0.5ml IM Nimenrix® 0.5ml IM

DATE	TIME	LOT # AND EXPIRY	DELTOID SITE		SIGNATURE	DATA ENTERED
			R	L		

Human Papillomavirus (HPV-9) Vaccine (2 doses) Gardasil®9 0.5ml IM

DOSE	DATE	TIME	LOT # AND EXPIRY	DELTOID SITE		SIGNATURE	DATA ENTERED
1				R	L		
2				R	L		

Hepatitis B Vaccine (2 doses) Engerix-B® 1.0ml IM Recombivax-HB® 1.0 ml IM

DOSE	DATE	TIME	LOT # AND EXPIRY	DELTOID SITE		SIGNATURE	DATA ENTERED
1				R	L		
2				R	L		

NURSE'S NOTES
