SOUTHWESTERN Public Health
Oxford • Elgin • St.Thomas

St. Thomas Site
Administrative Office
1230 Talbot Street
St. Thomas, ON
N5P 1G9

Woodstock Site
410 Buller Street
Woodstock, ON
N4S 4N2

SCHOOL IMMUNIZATION CONSENT FORM

1. STUDENT PERSONAL INFORMATION

Last Name	First Name	Preferred Name	
Preferred Pronoun (She / He / They)		Ontario Health Card #	
Date of Birth Year / Month / Day	School		Teacher's Name
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?	◯ YES ◯ NO	
Has your child ever had a reaction to a vaccine?	◯ YES ◯ NO	
Does your child have a history of fainting or seizures?	◯ YES ◯ NO	
Does your child have a serious medical condition?	◯ YES ◯ NO	

3. STUDENT IMMUNIZATION HISTORY

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

◯ Hepatitis B vaccine
Engerix®-B / Recombivax-HB®

Dates: yyyy/mm/dd yyyy/mm/dd yyyy/mm/dd

◯ Meningococcal A,C,Y,W-135 vaccine
Menactra® / Menveo™ / Nimenrix®
(Do NOT include Men-C-C vaccines - eg. Menjugate®, NeisVac-C®)

Date: yyyy/mm/dd

◯ Combination Hepatitis A & B vaccine
Twinrix® Jr. / Twinrix®

Dates: yyyy/mm/dd yyyy/mm/dd yyyy/mm/dd

◯ Human Papillomavirus vaccine
Gardasil® / Cervarix® / Gardasil® 9

Dates: yyyy/mm/dd yyyy/mm/dd yyyy/mm/dd

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