

## SCHOOL VACCINATION CONSENT FORM

### INSTRUCTIONS FOR PARENT/GUARDIAN

1. Read the attached information about the Hep B, HPV-9 and Men-C-ACYW-135 vaccines.
2. Complete the **front page only**.
3. Return this signed consent to your child's teacher.

### 1. STUDENT INFORMATION

Last Name	First Name	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Male	Female	Other
Birthday Year                      Month                      Day	School			
Parent/Guardian Name and Relationship to Student	Daytime Phone	Work or Cell		

### 2. STUDENT HEALTH HISTORY

If yes, please explain:

Does your child have any allergies?	<input type="radio"/>	<input type="radio"/>	
	Yes	No	
Has your child ever reacted to a vaccine?	<input type="radio"/>	<input type="radio"/>	
	Yes	No	
Does your child have a history of fainting or seizures?	<input type="radio"/>	<input type="radio"/>	
	Yes	No	
Does your child have a serious medical condition or take any medication that weakens the immune system?	<input type="radio"/>	<input type="radio"/>	
	Yes	No	

### 3. VACCINATION HISTORY

Has your child received any of these vaccines before? If yes, please complete the table below.

<b>Meningococcal Conjugate A-C-Y-W-135</b>	<input type="radio"/> Menactra®	<input type="radio"/> Menveo®	<input type="radio"/> Nimenrix®	Single dose: YYYY / MM / DD
<b>Hepatitis B</b>	<input type="radio"/> INFANRIX-hexa®	<input type="radio"/> Engerix®-B	<input type="radio"/> Twinrix®	Dose 1: YYYY / MM / DD
	<input type="radio"/> Recombivax-HB®	<input type="radio"/> Twinrix® Jr.		Dose 2: YYYY / MM / DD
				Dose 3: YYYY / MM / DD
<b>Human Papillomavirus Vaccine</b>	<input type="radio"/> Gardasil®	<input type="radio"/> Gardasil®-9	<input type="radio"/> Cervarix®	Dose 1: YYYY / MM / DD
				Dose 2: YYYY / MM / DD

### 4. PERMISSION FOR VACCINATION

I have read or had explained to me the attached information about the Hepatitis B, HPV-9 and Men-C-ACYW135 vaccines. This permission form is valid until August 31<sup>st</sup>, 2021. However, I understand that I can withdraw permission at any time by calling Hamilton Public Health at 905-546-2424 ext. 7556.

Meningitis Vaccine		
I give Hamilton Public Health permission to administer 1 dose of Men-C-ACYW135 vaccine. <i>This vaccine is required for school attendance.</i>	<input type="radio"/>	<input type="radio"/>
	<b>YES</b>	<b>NO</b>
Hepatitis B Vaccine		
I give Hamilton Public Health permission to administer 2 doses of Hepatitis B vaccine given at least 6 months apart.	<input type="radio"/>	<input type="radio"/>
	<b>YES</b>	<b>NO</b>
HPV Vaccine		
I give Hamilton Public Health permission to administer 2 doses of Human Papillomavirus vaccine given at least 6 months apart.	<input type="radio"/>	<input type="radio"/>
	<b>YES</b>	<b>NO</b>

X \_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_ Date

### COLLECTION AND USE OF PERSONAL HEALTH INFORMATION

The personal health information on this form is collected under the *Personal Health Information Protection Act, 2004*. The City of Hamilton Public Health Services (PHS) will use the information you provide for purposes permitted or required by law like to help treat and care for you and to plan, administer and evaluate PHS programs and services.

If you have any questions about the collection or use of your information or if you would like to withdraw your consent, please contact PHS Vaccine Program by phone at (905) 546-2424 x 7556 or by mail at 110 King St. W, 2<sup>nd</sup> Floor, Hamilton, Ontario, L8N 4S6.

Student Last Name

Student First Name

DOB

**FOR NURSES USE ONLY****Men-C-ACYW135****Hepatitis B****HPV-9**

Has the parent given permission?	Dose 1:		Dose 1:		Dose 2:		Dose 1:		Dose 2:	
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

**NURSE'S ASSESSMENT** (Ensure initials are being used to indicate each answer)

	Dose 1	Dose 2	Notes:
Do you have a fever or are you sick today?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
Has anything changed with your health recently?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
Did you react to a previous dose of a vaccine?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
Females only: Is there a chance you could be pregnant?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
Do you understand what the vaccines are for? Health teaching provided as needed.	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	
Do you have any questions? Health teaching provided as needed.	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	

**CONSENT FOR VACCINATION**

Student  \_\_\_\_\_  
Round #1 Signature \_\_\_\_\_ Date \_\_\_\_\_

Student  \_\_\_\_\_  
Round #2 Signature \_\_\_\_\_ Date \_\_\_\_\_

Substitute Decision Maker (SDM) (check only if SDM has given permission written or verbally)

Nurse's Rationale Round 1: \_\_\_\_\_

Nurse's Rationale Round 2: \_\_\_\_\_

**VACCINE INFORMATION**

The following vaccines were administered intramuscularly as per the EW&CDC Medical Directives 01-03-01 Meningococcal Conjugate A-C-Y-W-135 Vaccine, 01-03-11 Hepatitis B Vaccine and 01-03-12 Human Papillomavirus Vaccine authorized by Dr. Richardson, Dr. Tran and Dr. Harvey.

Meningococcal Conjugate A-C-Y-W-135 Vaccine						
	Date & Time	Lot #	Vaccine	Site*: Deltoid	Signature	Panorama Entry Date & Initial
1			<input type="radio"/> Menactra® 0.5mL	LS RS LI RI		
Hepatitis B Vaccine						
	Date & Time	Lot #	Vaccine	Site*: Deltoid	Signature	Panorama Entry Date & Initial
1			<input type="radio"/> Engerix®-B 1mL <input type="radio"/> Recombivax HB® 1mL	LS RS LI RI		
2			<input type="radio"/> Engerix®-B 1 mL <input type="radio"/> Recombivax HB® 1mL	LS RS LI RI		
Human Papillomavirus Vaccine						
	Date & Time	Lot #	Vaccine	Site*: Deltoid	Signature	Panorama Entry Date & Initial
1			<input type="radio"/> Gardasil®9 0.5mL	LS RS LI RI		
2			<input type="radio"/> Gardasil®9 0.5mL	LS RS LI RI		

**NOTES:**


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\* *LS = Left Superior, LI = Left inferior, RS = Right Superior, RI = Right Inferior*