VACCINE CONSENT

School Immunization Program

HASTINGS PRINCE EDWARD Public Health

Student's Last Name: _____ **Student's First Name:** _____ ☐**male** ☐**female** ☐**other**

Date of Birth (Y/M/D) _____ **School:** _____ **Room/Teacher** _____

Ontario Health Card # ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ **Allergies:** _____

Does your child have any conditions or take any medications that might affect their neurological or immune system (such as: unstable epilepsy, a bleeding disorder, cancer treatment, medications for Crohns disease, severe asthma)?
NO ☐ YES ☐

If YES - details: _____

Parent/Guardian's Name: _____ Tel: _____

PARENT/GUARDIAN CONSENT

- I have read or had explained to me the information about these vaccines. I have had the chance to ask questions which were answered to my satisfaction. I understand the risks, benefits and possible side effects of receiving each vaccine.
- The following consent is valid for the time needed to give all doses of the vaccines unless I cancel my consent.
- By signing below, I consent for the following vaccines to be given (check yes for each vaccine).
- I understand the student may receive up to three needles at one time.

1. MENINGOCOCCAL ACYW-135 (MENACTRA or MENVEO VACCINE)

SIGN BELOW: ☐ **YES,** Please vaccinate my child **OR** ☐ **NO,** Do NOT vaccinate my child, with one dose of Menactra or Menveo		
X _____	**X**_____	**X** _____
Signature of Parent/Legal Guardian	Print name of Parent/Legal Guardian	Date
Date of doses previously given (YY/MM/DD)	**Name of previous meningococcal ACYW-135 vaccine given: (Please do <u>NOT</u> include MEN-C vaccines-eg. Menjugate/Neis-Vac C)**	

2. HEPATITIS B VACCINE (RECOMBIVAX HB/ENGERIX B VACCINE)

SIGN BELOW: ☐ **YES**, Please vaccinate my child **OR** ☐ **NO**, Do NOT vaccinate my child, with two doses of Hepatitis B vaccine		
X _____	**X**_____	**X** _____
Signature of Parent/Legal Guardian	Print name of Parent/Legal Guardian	Date
Date of doses previously given (YY/MM/DD)	**Name of previous vaccine given: eg. Hepatitis B, Engerix B, Recombivax HB, Twinrix Jr**	

3. HUMAN PAPILLOMA VIRUS – HPV (GARDASIL 9 VACCINE)

SIGN BELOW: ☐ **YES,** Please vaccinate my child **OR** ☐ **NO,** Do NOT vaccinate my child, with two doses of Gardasil 9 vaccine		
X _____	**X**_____	**X** _____
Signature of Parent/Legal Guardian	Print name of Parent/Legal Guardian	Date
Date of doses previously given (YY/MM/DD)	**Name of previous HPV vaccine given:**	

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