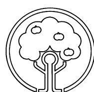

RENFREW COUNTY AND DISTRICT HEALTH UNIT

HUMAN PAPILLOMAVIRUS VACCINE CONSENT FORM FOR GRADE 8 FEMALES

Student:______________________________ **School:** ______________________
(Last Name) (First Name)

Parent/Guardian:______________________________ **Telephone:**______________________________
(Last Name) (First Name) (Home) (Work)

Mailing Address: ____
(Street, P.O. Box, Rural Route) (City) (Postal Code)

Ontario Health Card #:______________________ **Birth Date:** ______________________
(Optional) Year Month Day

Please print clearly and complete the appropriate section(s).

YES, **I consent to have Renfrew County and District Health Unit administer the Human Papillomavirus (HPV) vaccine to** ______________________________ **to complete the HPV vaccination series.**
(Student's Name)

I have read the Renfrew County and District Health Unit HPV vaccine fact sheet. I understand the benefits, risks and possible side effects of the HPV vaccine. I understand I can withdraw my consent in writing at any time.

Date: ______________________ Signature: ______________________________
yyyy/mm/dd (Parent / Legal Guardian)

Daytime Telephone Number: (_______)______________________________

OR

MY DAUGHTER HAS ALREADY RECEIVED THE HPV VACCINE (e.g. Gardasil®)

Please provide the dates below. Three shots are required for full protection. If your daughter has not received all three shots, please sign the above consent form to ensure she is fully protected.

Date of First Dose ______________________
Date of Second Dose ______________________
Date of Third Dose ______________________

If your daughter has received 3 doses, no additional doses are required at this time.

Please answer all questions below.

#	Student's Health History Questions	NO	YES	If "Yes", briefly describe
1.	Is this student allergic to the following: • Aluminium • Yeast • Sodium chloride **Note: there is no antibiotic, preservative, latex or thimerosal in this vaccine.**			
2.	Has this student ever had a serious reaction to any vaccine in the past?			

Personal health information contained on this form is collected under the authority of one or more of the following (as amended): the Health Protection and Promotion Act, R.S.O. 1990; the Immunization of School Pupils Act, R.S.O. 1990; the Regulated Health Professions Act, 1991, S.O. 1991; and is in compliance with the Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990 and the Personal Health Information Protection Act, 2004, S.O. 2004. This information is used to ensure that all appropriate personal care and public health services are provided, and that necessary statistics are kept. Questions about this collection should be directed to the Program Manager at the Renfrew County and District Health Unit, 7 International Drive, Pembroke, ON K8A 6W5, 613-735-8651 or visit our Privacy Statement at www.rcdhu.com.

Student's Name:________________________ DOB: ____________________

FOR NURSE'S USE ONLY

Human Papillomavirus (HPV) Vaccine for Grade 8 Females

NURSING ASSESSMENT QUESTIONS	DOSE ONE	DOSE TWO		DOSE THREE (only if required)
1. a) How old are you? b) Do you understand what the needle is for?	________ ❑ yes ❑ no	________ ❑ yes ❑ no		________ ❑ yes ❑ no
2. Have you received needles for Human Papillomavirus (HPV) immunization before today?	❑ yes ❑ no	**Dose ONE Date Checked Adequate Spacing Evident (≥6 months)** ❑ yes ❑ no **Initials:** _____	**Dose ONE Adequate Spacing Evident (≥30 days)** ❑ yes ❑ no **Initials:** _____	**Dose Two Date Checked Adequate Spacing Evident (≥90 days)** ❑ yes ❑ no **Initials** _____
3. Have you ever had a reaction to any immunization in the past? (including the HPV needle)	❑ yes ❑ no	❑ yes ❑ no ❑ yes ❑ no		❑ yes ❑ no ❑ yes ❑ no
4. Are you sick today ? Do you have a fever?	❑ yes ❑ no ❑ yes ❑ no	❑ yes ❑ no ❑ yes ❑ no		❑ yes ❑ no ❑ yes ❑ no
5. Do you have any serious health problems? Are you taking any medication that may lower your immune system, such as cancer therapy?	❑ yes ❑ no ❑ yes ❑ no Comments:	❑ yes ❑ no ❑ yes ❑ no Comments:		❑ yes ❑ no ❑ yes ❑ no Comments:
7. Do you think you might be pregnant?	❑ yes ❑ no	❑ yes ❑ no		❑ yes ❑ no
	Vaccine: Gardasil® Dose: 0.5ml Lot # ________ Expiry Date: R / L deltoid Route:___IM________ Date:_____________ Time:_____________ _______________ Signature of Nurse	Vaccine: Gardasil® Dose: 0.5ml Lot # ________ Expiry Date: R / L deltoid Route:___IM________ Date:_____________ Time:_____________ _______________ Signature of Nurse		Vaccine: Gardasil® Dose: 0.5ml Lot # ________ Expiry Date: R / L deltoid Route:___IM________ Date:_____________ Time:_____________ _______________ Signature of Nurse

Nursing Notes: