Renfrew County and District Health Unit

CONSENT FORM

Meningococcal, Hepatitis B and Human Papillomavirus Vaccinations

Student Information:

Last Name	First Name	Ontario Health Card (optional)	Male ◯	Female ◯	Other ◯
Date of Birth (YYYY/MM/DD)	School		Class or Teacher's Name		
Parent/ Legal Guardian Name- Please print	Relationship to Student	Home Phone number	Work or Cell number		

Complete the following questions:

	No	*Yes*	*If "Yes", briefly describe*
Does your child have a serious medical condition?			
Has your child ever had a reaction(s) to any vaccines or a history of fainting?			
Is your child allergic to latex, yeast, aluminum, diphtheria toxoid protein, other?			
Is this student pregnant?			

My child has already received the following: (If possible circle applicable trade name and provide date vaccines were given)

◯ **Hepatitis B vaccine** *Engerix®- B or Recombivax- HB®* Date: _____ _____ _____ YYYY/MM/DD YYYY/MM/DD YYYY/MM/DD	◯ **Meningococcal- ACYW-135 vaccine** *Menactra®or Menveo™ or Nimenrix®* Date: _____ YYYY/MM/DD
◯ **Combination Hepatitis A & B vaccine** *Twinrix® Jr. or Twinrix®* Date: _____ _____ _____ YYYY/MM/DD YYYY/MM/DD YYYY/MM/DD	◯ **Human papillomavirus vaccine** *Gardasil ® or Cervarix ®* Date: _____ _____ _____ YYYY/MM/DD YYYY/MM/DD YYYY/MM/DD

Please complete consent for <u>EACH</u> Immunization:

<u>Meningococcal Conjugate ACYW-135 Vaccine</u>: Mandatory Vaccine- One dose

Consent for vaccination:

I have read the attached Meningococcal Conjugate ACYW-135 vaccine fact sheet. I understand the expected benefits and possible side effects. If you or your child chooses to not get this vaccine, the Health Unit requires a valid exemption from immunization. Please contact RCDHU at 613-735-8653 or 800-267-1097 to discuss the process.

- O **Yes.** I authorize RCDHU to administer one dose of Meningococcal-ACYW-135 to my child.
- O **No.** I do not authorize RCDHU to vaccinate my child with the Meningococcal-ACYW-135 vaccine.

Signature: X _____ **Date** _____

<u>Hepatitis B Vaccine</u>: Voluntary Vaccine - Two dose series, separated by 4-6 months.

Consent for vaccination:

I have read the attached Hepatitis B vaccine fact sheet. I understand the expected benefits and possible side effects.

- O **Yes.** I authorize RCDHU to administer the required series of Hepatitis B to my child.
- O **No.** I do not authorize RCDHU to vaccinate my child with the Hepatitis B vaccine.

Signature: X _____ **Date** _____

<u>Human Papillomavirus Vaccine (HPV)</u>: Voluntary Vaccine - Two doses (or 3 doses if starting on or after the 14th birthday)

Consent for vaccination:

I have read the attached Human Papillomavirus Vaccine fact sheet. I understand the expected benefits and possible side effects.

- O **Yes.** I authorize RCDHU to administer the required series of HPV vaccine to my child.
- O **No.** I do not authorize RCDHU to vaccinate my child with the HPV vaccine.

Signature: X _____ **Date** _____

Student's Name: _____ DOB: _____

FOR NURSE'S USE ONLY

NURSE TO COMPLETE ON CLINIC DAY	VISIT 1 DATE: _____	VISIT 2 DATE: _____	VISIT 3 DATE: _____
HPV 2-dose schedule: is there a minimum of 6 months since dose 1?	Not applicable	◯ YES ◯ NO	◯ YES ◯ NO
Hepatitis 2-dose schedule: is there a minimum of 4 months since dose 1 (Recombivax), is there a minimum of 6 months since dose 1 (Engerix)?	Not applicable	◯ YES ◯ NO	◯ YES ◯ NO
Have you received hepatitis B, HPV or meningococcal vaccine from another health care provider?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
Do you understand what the vaccine(s) are for?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
Have you ever had a reaction to a vaccine?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
Do you have any allergies?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
Has anything changed with your health recently?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
Do you have a fever today?	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO
Do you think you may be pregnant? ◯ N/A	◯ YES ◯ NO	◯ YES ◯ NO	◯ YES ◯ NO

MENINGOCOCCAL-ACYW-135 VACCINE (Menactra®)

Dose: 0.5 mL

IM DELTOID: Left Right

DATE _____ **LOT #** _____

TIME _____ **SIGNATURE** _____

Panorama entered by:

HEPATITIS B VACCINE

Dose 1

◯ **Engerix®-B 1.0mL / 0.5mL IM**

◯ **Recombivax HB® 1.0mL / 0.5mL IM**

DATE _____

TIME _____

LOT # _____

DELTOID: Left Right

SIGNATURE:

Panorama entered by:

Dose 2

◯ **Engerix®-B 1.0mL / 0.5mL IM**

◯ **Recombivax HB® 1.0mL / 0.5mL IM**

DATE _____

TIME _____

LOT # _____

DELTOID: Left Right

SIGNATURE:

Panorama entered by:

HUMAN PAPILLOMAVIRUS VACCINE (Gardasil®)

Dose 1: 0.5 mL

DATE _____

TIME _____

LOT # _____

IM DELTOID: Left Right

SIGNATURE:

Panorama entered by:

Dose 2: 0.5 mL

DATE _____

TIME _____

LOT # _____

IM DELTOID: Left Right

SIGNATURE:

Panorama entered by:

Dose 3 (if required**): 0.5 mL**

DATE _____

TIME _____

LOT # _____

IM DELTOID: Left Right

SIGNATURE:

Panorama entered by:

NOTES

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