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.

First Name

- 2. Complete the front page only.
- 3. Return this signed consent to your child's teacher.

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|---|-------|----|-----|---|-----|----|-----|-----|
|---|-------|----|-----|---|-----|----|-----|-----|

Last Name

| | | | | | | O | \cup |
|---|---------------|--------|-------|-------------|------------|--------------|--------|
| | | | | | Male | Female | Other |
| | School | | | | | | |
| Year Month Day | | | | | | | |
| Parent/Guardian Name and Relationship to Student | Daytime Phone | | | | Work or 0 | Cell | |
| | | | | | | | |
| 2. STUDENT HEALTH HISTORY | | | ı | f yes, plea | se explair | າ: | |
| | | | 0 | | | | |
| Does your child have any allergies? | | | _ | | | | |
| | | Yes | No | | | | |
| Has your child ever reacted to a vaccine? | | | 0 | | | | |
| That year orma ever reacted to a vaccine. | | Yes | No | | | | |
| Does your child have a history of fainting or seizures? | | | 0 | | | | |
| | | | No | | | | |
| Does your child have a serious medical condition or take any medication that weakens the immune system? | | | 0 | | | | |
| | | | _ | | | | |
| | | | No | | | | |
| | | | | | | | |
| 3. VACCINATION HISTORY | | | | | | | |
| Has your shild received any of those vaccines | hoforo? If vo | s nlos | 00.00 | amplata the | table bole | 314 / | |

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

| Meningococcal Conjugate A-C-Y-W-135 | O Menactra® | O Menveo® | O Nimenrix® | Single dose: YYYY / MM / DD |
|--|-----------------------------------|-----------------------------|-------------------------|--|
| Hepatitis B | O INFANRIX-hexa® O Recombivax-HB® | O Engerix®-B O Twinrix® Jr. | O Twinrix® | Dose 1: YYYY / MM / DD Dose 2: YYYY / MM / DD Dose 3: YYYY / MM / DD |
| Human Papillomavirus Vaccine | ○ Gardasil® | O Gardasil [®] -9 | O 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 31st, 2024. 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. This vaccine is required for school attendance. | 0 | 0 | | | |
| i nis vaccine is requireα for school attendance. | | | | | |
| Hepatitis B Vaccine | | | | | |
| I give Hamilton Public Health permission to administer 2 doses of Hepatitis B vaccine given at least 6 months apart. | | 0 | | | |
| | YES | NO | | | |
| HPV Vaccine | | | | | |
| I give Hamilton Public Health permission to administer 2 doses of Human Papillomavirus vaccine given at least 6 months apart. | | | | | |
| vaconie given at least o months apart. | YES | NO | | | |
| XSignature 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, 2nd Floor, Hamilton, Ontario, L8N 4S6.

| Student Last Name | Student First Name | DOB |
|-------------------|--------------------|-----|
| | | |

| | | FOR | NURSES USI | E ONL | Υ | | | | | |
|--|--|--|---|--------------------------------|---|---------------------|----------------|---------------------|-------------------------------------|-----------------------------|
| | Men-C-ACY\ | | | atitis | | | | | HPV-9 | |
| Has the | Dose 1: | | Dose 1: | | Dose 2: | | [| Oose 1: | | Dose 2: |
| parent given | 0 0 | | | | 0 0 | | | | | 0 0 |
| permission? | 0 0 | | 0 0 | | 0 0 | | (| 0 0 | | 0 0 |
| | Yes No | | Yes No | | Yes No | | | es No | | Yes No |
| URSE'S ASSESSM | IENT (Ensure | e initials are b | eing used to i | | | | | | | |
| | | | | Do | ose 1 | Dos | e 2 | Notes | : | |
| Do you have a feve | r or are vou si | ick today? | | С | 0 | 0 | 0 | | | |
| | | | | Ye | es No | Yes | No | | | |
| Joo onything chang | and with your l | haalth raaantl | lu O | | 0 | 0 | 0 | | | |
| Has anything chang | jea with your i | nealth recent | ıy : | Ye | • | | No | | | |
| | | | | | _ | _ | _ | | | |
| Did you react to a p | revious dose | of a vaccine? | 1 | C | • | 0 | 0 | | | |
| | | | | Ye | es No | Yes | No | | | |
| Females only: Is the | ere a chance y | you could be | pregnant? | |) () | 0 | 0 | | | |
| | | | | Ye | es No | Yes | No | | | |
| Oo you understand | | cines are for? | Health | С | 0 | 0 | 0 | | | |
| eaching provided a | s needed. | | | Ye | es No | Yes | No | | | |
| Do you have any qu | uestions? Hea | alth teaching | provided as | |) () | 0 | 0 | | | |
| needed. | | | - | | es No | Yes | • | | | |
| Student X | | Round #1 Sigr | | | | | | | Date | |
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^{*} LS = Left Superior, LI = Left inferior, RS = Right Superior, RI = Right Inferior