SCHOOL VACCINATION CONSENT FORM

Hamilton Public Health Services

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	○ 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?	○ Yes ○ No	
Has your child ever reacted to a vaccine?	○ Yes ○ No	
Does your child have a history of fainting or seizures?	○ Yes ○ No	
Does your child have a serious medical condition or take any medication that weakens the immune system?	○ Yes ○ No	

3. VACCINATION HISTORY

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

Meningococcal Conjugate A-C-Y-W-135	○ Menactra® ○ Menveo® ○ Nimenrix®	Single dose: YYYY / MM / DD
Hepatitis B	○ INFANRIX-hexa® ○ Engerix®-B ○ Twinrix® ○ Recombivax-HB® ○ Twinrix® Jr.	Dose 1: YYYY / MM / DD Dose 2: YYYY / MM / DD Dose 3: YYYY / MM / DD
Human Papillomavirus Vaccine	○ Gardasil® ○ Gardasil®-9 ○ 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.*	○ **YES**	○ **NO**
Hepatitis B Vaccine		
I give Hamilton Public Health permission to administer 2 doses of Hepatitis B vaccine given at least 6 months apart.	○ **YES**	○ **NO**
HPV Vaccine		
I give Hamilton Public Health permission to administer 2 doses of Human Papillomavirus vaccine given at least 6 months apart.	○ **YES**	○ **NO**

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, 2nd 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: ○ ○ Yes No	Dose 1: ○ ○ Yes No	Dose 2: ○ ○ Yes No	Dose 1: ○ ○ Yes No	Dose 2: ○ ○ 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?	○ ○ Yes No	○ ○ Yes No	
Has anything changed with your health recently?	○ ○ Yes No	○ ○ Yes No	
Did you react to a previous dose of a vaccine?	○ ○ Yes No	○ ○ Yes No	
Females only: Is there a chance you could be pregnant?	○ ○ Yes No	○ ○ Yes No	
Do you understand what the vaccines are for? Health teaching provided as needed.	○ ○ Yes No	○ ○ Yes No	
Do you have any questions? Health teaching provided as needed.	○ ○ Yes No	○ ○ Yes No	

CONSENT FOR VACCINATION

○ Student X_____ _____
Round #1 Signature Date

○ Student X_____ _____
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 and Dr. Harvey.

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