CK Public Health

SCHOOL IMMUNIZATION CONSENT

1. STUDENT INFORMATION

Student's Name: (Last) _____ **(First)** _____

I identify as: ☐ **M** ☐ **F** ☐ _____ **Birth Date: (Year/Month/Day)** _____

Health Card Number: _____ **Healthcare provider:** _____

Primary Phone: _____ **Alternate Phone:** _____

School: _____ **Teacher:** _____

RETURN TO SCHOOL BY:

2. STUDENT HEALTH HISTORY (please check boxes)

Does your child have any known allergies? (food, drugs, yeast, latex) ☐ No ☐ Yes
If yes, please explain: _____

Has your child ever had a reaction to a shot? ☐ No ☐ Yes
If yes, please explain: _____

Does your child have any medical conditions or take any medications on a regular basis? ☐ No ☐ Yes
If yes, please explain: _____

3. CONSENT FOR IMMUNIZATION

Hepatitis B	Meningococcal	Human Papillomavirus (HPV-9)
☐ YES my child may be given the shot against hepatitis B. _____ Parent/Guardian Signature _____ Date ☐ NO I do not consent for my child to be given the shot against hepatitis B. _____ Parent/Guardian Signature _____ Date My child has already received the hepatitis B vaccine: ☐ Hep B ☐ Twinrix Dates: 1. _____ yyyy/mm/dd 2. _____ yyyy/mm/dd 3. _____ yyyy/mm/dd	☐ YES my child may be given the shot against meningococcal disease (ACYW-135). _____ Parent/Guardian Signature _____ Date ☐ NO I do not consent for my child to be given the shot against meningococcal disease (ACYW-135). _____ Parent/Guardian Signature _____ Date My child has already received the meningococcal ACYW-135 vaccine. Date: _____ (yyyy/mm/dd) ***This is a required vaccine. It is different than the vaccine given on or after the 1st birthday.**	☐ YES my child may be given the shot against HPV-9. _____ Parent/Guardian Signature _____ Date ☐ NO I do not consent for my child to be given the shot against HPV-9. _____ Parent/Guardian Signature _____ Date My child has already received the HPV vaccine. Dates: 1. _____ yyyy/mm/dd 2. _____ yyyy/mm/dd 3. _____ yyyy/mm/dd

Unless cancelled, this request is valid for the time period required to complete the series.

For more information, call CK Public Health at 519.355.1071 ext. 5900.

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FOR NURSES USE ONLY

Dose #1 **HEPATITIS B** Recombivax/Engerix B Dose: 1.0ml Site: R L deltoid (circle one) Lot#:_____ Route: IM Date:_____ Time:_____ Signature of Nurse: _____	Dose #1 **MEN-C-ACYW-135** Dose: 0.5ml Site: R L deltoid (circle one) Lot#:_____ Route: IM Date:_____ Time:_____ Signature of Nurse: _____	Dose #1 **HPV-9** Dose: 0.5ml Site: R L deltoid (circle one) Lot#:_____ Route: IM Date:_____ Time:_____ Signature of Nurse: _____
Dose #2 Is adequate spacing evident? Recombivax ≥ 4mos.; Engerix ≥ 6 mos. Dose: 1.0ml Site: R L deltoid (circle one) Lot#:_____ Route: IM Date:_____ Time:_____ Signature of Nurse: _____		Dose #2 If <15 years of age at first dose, is adequate spacing evident? (≥ 6mos.) Dose: 0.5ml Site: R L deltoid (circle one) Lot#:_____ Route: IM Date:_____ Time:_____ Signature of Nurse: _____
Nurses Notes:		

Information is collected under the authority of the Health Protection and Promotion Act RSO 1990. This information is used by the Medical Officer of Health to monitor immunization status in the community. Please note that all immunization information is confidential. However, for the purpose of ensuring continuity of care, this information will be released to your primary care practitioner upon his/her request unless you specifically request the health unit to withhold immunization information.