Chatham-Kent Public Health

SCHOOL IMMUNIZATION CONSENT

1. STUDENT INFORMATION

Student Name:			
Last	First Birth Date: (Vear/Mont	Preferred	
I Identify As: 🗌 M 🔤 F 🔤 Birth Date: (Year/Month/Day)			
Health Card Number:	Physician/NP Name: _		
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)			
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			
3. CONSENT FOR IMMUNIZATION			
Hepatitis B	Meningococcal (Men-C-ACYW)	Human Papillomavirus (HPV-9)	
☐ YES my child may be given the shot against hepatitis B.	YES my child may be given the shot against meningococcal disease (ACYW).	☐ YES my child may be given the shot against HPV-9.	
Parent/Guardian Signature	Parent/Guardian Signature	Parent/Guardian Signature	
Date	Date	Date	
☐ NO I do not consent for my child to be given the shot against hepatitis B.	□ NO I do not consent for my child to be given the shot against meningococcal disease (ACYW).	NO I do not consent for my child to be given the shot against HPV-9.	
My child has already received the hepatitis B vaccine:	My child has already received the meningococcal (ACYW) vaccine.	My child has already received the HPV vaccine.	
Hep B Twinrix 1. (yyyy/mm/dd) 2. (yyyy/mm/dd) 3. (yyyy/mm/dd)	Date: (yyyy/mm/dd) *This is a required vaccine. It is different than the vaccine given on or after the first birthday.	1. (yyyy/mm/dd) 2. (yyyy/mm/dd) 3. (yyyy/mm/dd)	



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NURSES USE ONLY

Dose #1 HEPATITIS B	Dose #1 MEN-C-ACYW	Dose #1 HPV-9
Recombivax/Engerix B	Menactra/Nimenrix/Menveo	
Dose:1.0ml Site: R L deltoid (circle one)	Dose:0.5ml Site: R L deltoid (circle one)	Dose:0.5ml Site: R L deltoid (circle one)
Lot#: Route: IM	Lot#: Route: IM	Lot#: Route: IM
Date: Time:	Date: Time:	Date: Time:
Signature of Nurse:	Signature of Nurse:	Signature of Nurse:
Dose #2		Dose #2
ls adequate spacing evident? Recombivax ≥ 4mos. Engerix ≥ 6 mos.		If <15 years of age at first dose, is adequate spacing evident? (≥ 6mos.)
Dose:1.0ml Site: R L deltoid (circle one)		Dose:0.5ml Site: R L deltoid (circle one)
Lot#: Route: IM		Lot#: Route: IM
Date: Time:		Date: Time:
Signature of Nurse:		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. May 2023