Peterborough Public Health

Consent Form for School-Based Vaccines:
Meningococcal C-ACYW-135, Hepatitis B and/or Human papillomavirus

1. Client Information (please print)						
Last Name			First Name		◯ Male ◯ Female ◯ Other	
Birthdate Year	Month	Day	School		Grade	
Address			City		Postal Code	
Parent/Legal Guardian Last Name			Parent/Legal Guardian First Name		Relationship to above named	
Cell/Home phone:			Work phone:		Email:	

2. **Client Health History:** Check yes or no if the above named have/are:		If yes, please provide details
a) known allergies to any of the vaccine components (refer to information sheet)	◯ YES ◯ NO	
b) reactions to previous vaccines	◯ YES ◯ NO	
c) a bleeding disorder	◯ YES ◯ NO	
d) a weak immune system or taking a medication that increases the risk of infection (e.g. corticosteroids)	◯ YES ◯ NO	
e) pregnant or breastfeeding	◯ YES ◯ NO	
f) previously received any of these vaccines . If yes, please provide the date of the vaccine.	◯ YES ◯ NO	Meningococcal C-ACYW-135 date:
	◯ YES ◯ NO	Human Papillomavirus (HPV) HPV4 ☐ date(s): HPV9 ☐ date(s):
	◯ YES ◯ NO	Hepatitis B date(s):

3. Consent for Vaccination: I have read the school-based vaccine information sheet. I understand the benefits, risks and side effects of the vaccines. I understand the risks to the above named client if they are not vaccinated. I have had the opportunity to have my questions answered by Public Health Nurses. This consent is valid until all doses have been administered. I understand that I can withdraw my consent at any time by calling Peterborough Public Health at 705-743-1000:

I consent to Public Health administering the **meningococcal C-ACYW135** vaccine to the above named client.	◯ YES ◯ NO
I consent to Public Health administering the **hepatitis B** vaccine to the above named client.	◯ YES ◯ NO
I consent to Public Health administering the **human papillomavirus** vaccine to the above named client.	◯ YES ◯ NO

X _____ _____

Signature of: ☐ **Parent** ☐ **Legal Guardian** ☐ **Client** **Date (YYYY/MM/DD)**

Personal health information on this form is collected under the authority of the Health Protection and Promotion Act, R.S.O. 1990, c.h.7 for the purpose of maintaining an immunization record for this individual. The confidentiality of this information is protected. For more information please contact our Freedom of Information Coordinator at Peterborough Public Health at 705-743-1000.

Public Health Use: Client ID:

Peterborough Public Health Use Only: Client Name/Client ID:

Meningococcal C-ACYW-135 Vaccine (Menactra®)

DATE (YYYY/MM/DD) ___________________ **TIME** ____________________ **LOT #** ____

IM DELTOID: ___ Left ___Right Dose: 0.5 mL NURSE SIGNATURE:____ ______**RN** ______**RPN**

Panorama Entry: Consent recorded _________ (initials) Imms recorded __________ (initials) Billing _____ (initials)

Hepatitis B Vaccine

____ **Engerix®-B** ___ **Recombivax HB®** **DATE** (YYYY/MM/DD)__________________ **TIME** ___________**LOT #** ________________________________

IM DELTOID: ___ Left ___ Right **Dosage:** ___ **1.0 mL** ___ **0.5 mL** NURSE SIGNATURE: ____________________________ ______**RN** _____**RPN**

Panorama Entry: Consent recorded _________ (initials) Imms recorded __________ (initials)

____ **Engerix®-B** ___ **Recombivax HB®** **DATE** (YYYY/MM/DD)__________________ **TIME** ___________**LOT #** ________________________________

IM DELTOID: ___ Left ___ Right **Dosage:** ___ **1.0 mL** ___ **0.5 mL** NURSE SIGNATURE: ____________________________ ______**RN** _____**RPN**

Panorama Entry: Consent recorded _________ (initials) Imms recorded __________ (initials)

____ **Engerix®-B** ___ **Recombivax HB®** **DATE** (YYYY/MM/DD)__________________ **TIME** ___________**LOT #** ________________________________

IM DELTOID: ___ Left ___ Right **Dosage:** ___ **1.0 mL** ___ **0.5 mL** NURSE SIGNATURE: ____________________________ ______**RN** _____**RPN**

Panorama Entry: Consent recorded _________ (initials) Imms recorded __________ (initials)

Human Papillomavirus Vaccine (Gardasil®4 or Gardasil®9)

___ **Gardasil®4** ___ **Gardasil®9** **DATE** (YYYY/MM/DD)__________________ **TIME** ___________**LOT #** ________________________________

IM DELTOID: ___ Left ___Right Dose: 0.5 mL NURSE SIGNATURE:____ ______**RN** ______**RPN**

Panorama Entry: Consent recorded _________ (initials) Imms recorded __________ (initials) Billing _____ (initials)

___ **Gardasil®4** ___ **Gardasil®9** **DATE** (YYYY/MM/DD)__________________ **TIME** ___________**LOT #** ________________________________

IM DELTOID: ___ Left ___Right Dose: 0.5 mL NURSE SIGNATURE:____ ______**RN** ______**RPN**

Panorama Entry: Consent recorded _________ (initials) Imms recorded __________ (initials) Billing _____ (initials)

___ **Gardasil®4** ___ **Gardasil®9** **DATE** (YYYY/MM/DD)__________________ **TIME** ___________**LOT #** ________________________________

IM DELTOID: ___ Left ___Right Dose: 0.5 mL NURSE SIGNATURE:____ ______**RN** ______**RPN**

Panorama Entry: Consent recorded _________ (initials) Imms recorded __________ (initials) Billing _____ (initials)

Notes: