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 details:	◯ YES ◯ NO	Meningococcal C-ACYW-135(Menactra) ☐ Meningococcal C-C (Menjugate) ☐ Date:
	◯ YES ◯ NO	Human papillomavirus 9 (HPV): Date(s):
	◯ YES ◯ NO	Hepatitis B Which vaccine: Hepatitis B or Twinrix 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. This vaccine is **required** under the Immunization of School Pupils Act.	◯ 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 9** vaccine to the above named client.	◯ YES ◯ NO

X _____ _____

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

Public Health Use: Client ID:

We collect, use and release your personal information under the authority of the Health Protection and Promotion Act, R.S.O. 1990, c.H.7., s. 5, the Immunization of School Pupils Act, R.S.O. 1990, s. 11(1)and its Regulation, and the Child Care and Early Years Act, S.O. 2014. The information is collected for the purpose of assessing, keeping records and reporting on the immunization status of individuals in the province of Ontario. Information collected is maintained electronically in a provincial immunization information system. Questions about this collection of information should be sent to the Privacy Officer, Peterborough Public Health, 185 King St., Peterborough, ON, K9J 2R8, (705) 743-1000.

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 2 doses (3 doses if ≥ 16 yrs)

____ **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 9 Vaccine (Gardasil ®) 2 doses (3 doses if ≥ 15 yrs)

___ **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 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 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: