Peterborough Public Health

Consent Form for School-Based Vaccines:
Meningococcal C-ACYW-135, Hepatitis B, Human papillomavirus (HPV 9)

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:	Teacher/Homeroom:			

2. Your Child's Vaccination History: If your child already received the following vaccine(s), please circle the trade name and provide date(s)

	Date vaccine was given		
	Dose 1	Dose 2	Dose 3
a) **Meningococcal C-ACYW-135 vaccine (special purchase e.g. for travel)** Menactra® Menveo® Nimenrix®	YY/MM/DD		
b) Human papillomavirus (HPV) vaccine (2 or 3 dose series) Gardasil® Gardisil-9® Cervarix®	YY/MM/DD	YY/MM/DD	YY/MM/DD
c) Hepatitis B (or combination) vaccine (2, 3 or 4 dose series) Engerix®-B Recombivax-HB® Twinrix®Jr Twinrix®	YY/MM/DD	YY/MM/DD	YY/MM/DD

3. 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) History of fainting	◯ YES ◯ NO	

3. Consent for Vaccination: I have read the school-based vaccine information sheet. I understand the possible benefits, risks and side effects of the vaccines. I understand the possible 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, ext. 139

I consent to Public Health administering the **meningococcal C-ACYW-135** 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)

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

Public Health Use: Client ID:

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:

Meningococcal C-ACYW-135 Vaccine

____ Menactra® ____ Nimenrix® DATE (YYYY/MM/DD)_________________ TIME __________LOT # _____________________________

IM DELTOID: ___ Left ___Right Dose: 0.5 mL NURSE SIGNATURE:_____________________________________ **_____RN _____RPN**

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**

____ 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**

____ 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**

Human Papillomavirus Vaccine — 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**

____Gardasil 9® DATE (YYYY/MM/DD)_________________ **TIME __________LOT #** _____________________________

IM DELTOID: ___ Left ___Right Dose: 0.5 mL NURSE SIGNATURE:_____________________________________ **_____RN _____RPN**

____Gardasil 9® DATE (YYYY/MM/DD)_________________ **TIME __________LOT #** _____________________________

IM DELTOID: ___ Left ___Right Dose: 0.5 mL NURSE SIGNATURE:_____________________________________ **_____RN _____RPN**

Notes: