

1. Client Information (please print)							
Last Name		First Name			<input type="radio"/> Male	<input type="radio"/> Female	<input type="radio"/> Other
Birthdate	Year	Month	Day	School			
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) allergies to any of the vaccine components (refer to information sheet)	<input type="radio"/> YES <input type="radio"/> NO
b) reactions to previous vaccines	<input type="radio"/> YES <input type="radio"/> NO
c) a bleeding disorder	<input type="radio"/> YES <input type="radio"/> NO
d) a weak immune system or taking a medication that increases the risk of infection (e.g. corticosteroids)	<input type="radio"/> YES <input type="radio"/> NO
e) pregnant or breastfeeding	<input type="radio"/> YES <input type="radio"/> NO
f) previously received any of these vaccines	<input type="radio"/> YES <input type="radio"/> NO
	Meningococcal C-ACYW-135 date:
	Human Papillomavirus date(s):
	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.	<input type="radio"/> YES <input type="radio"/> NO
I consent to Public Health administering the hepatitis B vaccine to the above named client.	<input type="radio"/> YES <input type="radio"/> NO
I consent to Public Health administering the human papillomavirus vaccine to the above named client.	<input type="radio"/> YES <input type="radio"/> 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)

Hepatitis B Vaccine

___ Enderix® -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)

___ Enderix® -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)

___ Enderix® -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®)

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)

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)

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)

Notes: