Ottawa | Public Health
Santé publique

School Clinic Vaccine Consent Form 2018-2019

Student's Last Name:_____ Student's First Name:_____

School:_____ Class:_____ Date of Birth (Y/M/D):_____

Answer the four questions about your child's health history. If you answer "yes", briefly describe.

1. Does the student have a serious medical condition? ◯ Yes ◯ No _____
2. Has the student ever had a reaction(s) to any vaccines? ◯ Yes ◯ No _____
3. Does the student have a history of fainting or seizures? ◯ Yes ◯ No _____
4. Does the student have any allergies? ◯ Yes ◯ No _____

Parent/Guardian's Name (Print):_____Tel.:_____

Parent/Guardian's Name (Print):_____Tel.:_____

Please indicate your consent "YES" or "NO" for each vaccine.

Meningococcal Conjugate ACYW-135 Vaccine (required for school attendance)

I have read the vaccine information sheet. I have had the chance to ask questions which were answered to my satisfaction. I understand the benefits and risks associated with this vaccine. I give consent to a nurse employed by Ottawa Public Health to administer the Meningococcal vaccine (one dose). This consent form is valid for up to 24 months unless consent is withdrawn verbally or in writing with Ottawa Public Health.

◯ Yes
Parent/Guardian's Signature:_____

Student Signature:_____

Date: Y/M/D_____

◯ No.
My child has received Menactra®, Menveo® or Nimenrix® on:
_____

Parent/Guardian's Signature:_____
Date: Y/M/D_____

Hepatitis B Vaccine

I have read the vaccine information sheet. I have had the chance to ask questions which were answered to my satisfaction. I understand the benefits and risks associated with this vaccine. I give consent to a nurse employed by Ottawa Public Health to administer the Hepatitis B vaccine (2 doses). This consent form is valid for up to 24 months unless consent is withdrawn verbally or in writing with Ottawa Public Health.

◯ Yes
Parent /Guardian's Signature:_____

Student Signature:_____

Date: Y/M/D _____

◯ No. My child has received Hepatitis B already (Twinrix®, Recombivax® HB or Engerix-B®)
Y/M/D _____

Parent /Guardian's Signature: _____
Date: Y/M/D _____

Human Papillomavirus Vaccine

I have read the vaccine information sheet. I have had the chance to ask questions which were answered to my satisfaction. I understand the benefits and risks associated with this vaccine. I give consent to a nurse employed by Ottawa Public Health to administer the HPV vaccines (2 or 3 doses depending upon my age). This consent form is valid for up to 24 months unless consent is withdrawn verbally or in writing with Ottawa Public Health

◯ Yes
Parent/Guardian's Signature: _____

Student Signature:_____
Date: Y/M/D_____

◯ No.

Parent/Guardian's Signature: _____
Date: Y/M/D _____

Personal Health Information is collected under the authority of Section 5 of the *Health Protection and Promotion Act* and will be used to administer vaccines including maintaining an immunization record for the vaccines. Questions regarding this collection and use of personal health information may be directed to the Supervisor, Immunization Unit, Ottawa Public Health by mail at 100 Constellation Drive, Ottawa, ON K2G 6J8, by telephone at 613-580-6744, or by e-mail at Immunization@ottawa.ca or visit the Information Practice Statement of the Medical Officer of Health at: http://ottawa.ca/en/city-hall/your-city-government/policies-and-administrative-structure/information-practice-statement

09/2018