Ottawa | Public Health
Santé publique

学校疫苗同意书

学生姓: ______________________________ 学生名: ______________________________

出生日期: ___________年/月/日___________

学校: 班级:

回答关于您孩子的病史的四个问题。如果您回答"是"，请简单描述一下。

1. 该学生是否有患有严重疾病? ☐ 否 ☐ 是: ______________________________
2. 该学生是否服药? ☐ 否 ☐ 是: ______________________________
3. 该学生是否对疫苗有过反应? ☐ 否 ☐ 是: ______________________________
4. 该学生有昏厥或癫痫病史吗? ☐ 否 ☐ 是: ______________________________
5. 该学生有任何过敏吗? ☐ 否 ☐ 是: ______________________________

请标明"是"（同意接种）或"否"（不同意接种）。本同意书有效期长达 24 个月，除非从渥太华公共卫生部门口头或书面撤回同意。

脑膜炎球菌结合疫苗 ACYW-135 (上学疫苗)	乙型肝炎疫苗(HB)	破伤风、白喉和无细胞百日咳疫苗 (Tdap)
我已阅读疫苗信息表。我已有机会问了一些问题，并得到了我满意的回答。我了解这个疫苗的好处和风险。我同意渥太华公共卫生部门的护士接种脑膜炎球菌疫苗（**若需要，接种一针**）。	我已阅读疫苗信息表。我有机会问了一些问题，并得到了我满意的回答。我了解这个疫苗的好处和风险。我同意由渥太华公共卫生部门雇用的一名护士来接种乙肝疫苗**(根据年龄接种 2 或 3 针。**	我已阅读疫苗信息表。我有机会问了一些问题，并得到了我满意的回答。我了解这个疫苗的好处和风险。我同意渥太华公共卫生部门雇用的一名护士为我接种破伤风、白喉和无细胞百日咳疫苗**(若需要，接种一针)。**
☐ 是 **姓名首字母:** ________	☐ 是 **姓名首字母:** ________	☐ 是 **姓名首字母:** ________
☐ 否 **姓名首字母:** ________	☐ 否 **姓名首字母:** ________	☐ 否 **姓名首字母:** ________

法定监护人全称 (正楷书写): ____________________________________ 关系: ________________________

法定监护人签名: ____ 日期: _________年/月/日_________

学生签名: ____ 日期: _________年/月/日_________

个人健康信息（PHI）是根据《健康保护和促进法》第 5 条的授权收集的，并将用于管理疫苗，包括保存疫苗的免疫记录。对收集和使用有疑问的话，请直接向 OPH 的免疫主管咨询：信件 100 Constellation Drive, Ottawa, ON K2G 6J8，电话 613-580-6744，或通过电子邮件 immunization@ottawa.ca 或阅读卫生医疗官的实践声明: https://ottawa.ca/en/city-hall/open-transparent-and-accountable-government/access-information-and-protection-privacy/protection-privacy/personal-health-information-protection

学校疫苗评估表(此页仅供临床使用)

学生姓: ______________________ 学生名: ______________________

出生日期: ________年/月/日________ 年龄: ______________________

客户身份证件: ______________________

注射检查的疫苗	获得同意(*首写字母*)	全图验证		剂次号
		正确间隔(*首写字母*)	需要剂量(*首写字母*)	
☐ **Men-C-ACYW-135**				__/ 1
☐ **HB**				__/__
☐ **HPV**				__/__
评估员签字和指定:			日期:	

我使用了两个客户标识符，根据对所有筛查问题的审查，客户没有接种疫苗的禁忌症。 首字母与指定:

____

Menactra® **Nimenrix®**

____

____

批号 稀释液 (仅 Nimenrix®)

剂量与途径:

☐ 0.5ml 肌肉

注射处:

☐左三角肌

☐右三角肌

接种:

时间:______________________

Engerix®-B **Recombivax®**

____

批号

剂量与途径:

☐ 1.0ml 肌肉

☐ 0.5ml 肌肉

注射处:

☐左三角肌

☐右三角肌

接种:

时间:______________________

日期:______________________

Gardasil®9

____

批号

剂量与途径:

☐ 0.5ml 肌肉

注射处:

☐左三角肌

☐右三角肌

接种:

时间:______________________

日期:______________________

Clinical Notes (date and time): ____

____

____

____**Signature and Designation:** ____

在全图中输入数据时姓名首写字母:__________ 在全图中输入数据的日期: ______________________

SCHOOL VACCINE CONSENT FORM

Student Last name: ______________________________ Student First name: ______________________________

Date of birth: ___________YYYY/MM/DD___________

School: ____ Class: ____

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

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

Please indicate your consent "YES" (vaccinate) or "NO" (DO NOT vaccinate) for EACH vaccine. This consent form is valid for up to 24 months unless consent is withdrawn verbally or in writing with Ottawa Public Health.

Meningococcal Conjugate ACYW-135 Vaccine (required for school attendance)	**Hepatitis B Vaccine (HB)**	**Human Papillomavirus Vaccine (HPV)**
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)**.	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 given 6 months apart).**	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 doses given 6 months apart.)**
☐ **Yes** **Initials:** ____________	☐ **Yes** **Initials:** ____________	☐ **Yes** **Initials:** ____________
☐ **No** **Initials:** ____________	☐ **No** **Initials:** ____________	☐ **No** **Initials:** ____________

Legal Guardian full name (print): ______________________________ Relationship: ____________________

Legal Guardian Signature: ______________________________ Date: _________YYYY/MM/DD_________

Student Signature: ______________________________ Date: _________YYYY/MM/DD_________

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: https://ottawa.ca/en/city-hall/open-transparent-and-accountable-government/access-information-and-protection-privacy/protection-privacy/personal-health-information-protection

SCHOOL VACCINE ASSESSMENT FORM (This side for clinic use

Student Last name: ________________________________ Student First name: ________________________________

Date of birth: ____________YYYY/MM/DD____________ Age: ____

Client ID: ____

Administer the checked vaccines	Consent Obtained *(Initial)*	Panorama Verified		Dose Number
		Correct Interval *(Initial)*	Requires Dose *(Initial)*	
☐ **Men-C-ACYW-135**				__/ 1
☐ **HB**				__/__
☐ **HPV**				__/__

Assessor Signature and Designation: ________________________ Date: ________________

I have used two client identifiers and the client has no contraindications to receiving the vaccine(s) based on the review of all screening questions. Initial & Designation: __________________

Menactra® **Nimenrix®**

________________ Lot number

____________________ Diluent (Nimenrix® only)

Dosage and Route:

☐ 0.5ml Intramuscular

Site:

☐ Left Deltoid

☐ Right Deltoid

Administration:

Time:_______________________

Date:_______________________

Signature and Designation:

____

Engerix®-B **Recombivax®**

__________________________ Lot number

Dosage and Route:

☐ 1.0ml Intramuscular

☐ 0.5ml Intramuscular

Site:

☐ Left Deltoid

☐ Right Deltoid

Administration:

Time:_______________________

Date:_______________________

Signature and Designation:

____

Gardasil®9

__________________________ Lot number

Dosage and Route:

☐ 0.5ml Intramuscular

Site:

☐ Left Deltoid

☐ Right Deltoid

Administration:

Time:_______________________

Date:_______________________

Signature and Designation:

____

Clinical Notes (date and time): ____

____

____

____**Signature and Designation:** ____

Initial when data entered in Panorama: _________ Date data entered in Panorama : _______________________