



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?	<input type="checkbox"/> No	<input type="checkbox"/> Yes: _____
2. Does the student take any medications?	<input type="checkbox"/> No	<input type="checkbox"/> Yes: _____
3. Has the student ever had a reaction(s) to any vaccines?	<input type="checkbox"/> No	<input type="checkbox"/> Yes: _____
4. Does the student have a history of fainting or seizures?	<input type="checkbox"/> No	<input type="checkbox"/> Yes: _____
5. Does the student have any allergies?	<input type="checkbox"/> No	<input type="checkbox"/> 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 This consent form is valid for up to 24 months unless consent is withdrawn verbally or in writing with Ottawa Public Health.

<p>Meningococcal Conjugate ACYW-135 Vaccine (required for school attendance)</p> <p>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).</p> <p><input type="checkbox"/> Yes Initials: _____</p> <p><input type="checkbox"/> No Initials: _____</p>	<p>Hepatitis B Vaccine (HB)</p> <p>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).</p> <p><input type="checkbox"/> Yes Initials: _____</p> <p><input type="checkbox"/> No Initials: _____</p>	<p>Human Papillomavirus Vaccine (HPV)</p> <p>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).</p> <p><input type="checkbox"/> Yes Initials: _____</p> <p><input type="checkbox"/> No Initials: _____</p>
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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>

