Ottawa Public Health | Santé publique

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 This consent form is valid for up to 24 months unless consent is withdrawn verbally or in writing with Ottawa Public Health.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)

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 **(if needed, one dose)**.

☐ **Yes** **Initials:** _____

☐ **No** **Initials:** _____

Hepatitis B Vaccine (HB)

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 **(if needed, 2 or 3 doses depending on age).**

☐ **Yes** **Initials:** _____

☐ **No** **Initials:** _____

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 HPV vaccine **(if needed, 2 or 3 doses depending on age).**

☐ **Yes** **Initials:** _____

☐ **No** **Initials:** _____

Tetanus, Diphtheria and Acellular Pertussis Vaccine (Tdap)

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 tetanus, diphtheria, and acellular pertussis vaccine **(if needed, one dose)**.

☐ **Yes** **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 (PHI) 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 PHI 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 only)

Student Last name: _____ Student First name: _____

Date of birth: _____YYYY/MM/DD_____ Age: _____

Client ID: _____

Panorama verified? Initial and Designation if yes: _____

Consent Obtained and Granted? Initial and Designation if yes: _____

Assessor Signature and Designation: _____

Date: _____

Administer the following checked vaccines:

- ☐ Men-C-ACYW-135 Dose: ___ /_1_
- ☐ HB Dose: ____ /____
- ☐ HPV Dose: ____ /____
- ☐ Tdap Dose: ____ /__1_

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®	**Engerix®-B Recombivax®**	**Gardasil®9**	**Adacel® Boostrix®**
_____ Lot Number _____ Diluent (Nimenrix® only)	_____ Lot number	_____ Lot number	_____ Lot number
Dosage and Route: ☐ 0.5ml Intramuscular	**Dosage and Route:** ☐ 1.0ml Intramuscular ☐ 0.5ml Intramuscular	**Dosage and Route:** ☐ 0.5ml Intramuscular	**Dosage and Route:** ☐ 0.5ml Intramuscular
Site: ☐ Left Deltoid ☐ Right Deltoid	**Site :** ☐ Left Deltoid ☐ Right Deltoid	**Site:** ☐ Left Deltoid ☐ Right Deltoid	**Site:** ☐ Left Deltoid ☐ Right Deltoid
Administration: Time:_____ Date:_____	**Administration:** Time:_____ Date:_____	**Administration:** Time:_____ Date:_____	**Administration:** Time:_____ Date:_____
Signature and Designation: _____	**Signature and Designation:** _____	**Signature and Designation:** _____	**Signature and Designation:** _____

Clinical Notes (date and time): _____

_____

_____

_____**Signature and Designation:** _____

Initial when data entered in Panorama: _____ Date data entered in Panorama : _____