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This consent form is valid for up to 24 months unless consent is withdrawn verbally or in writing with Ottawa Public Health.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

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SCHOOL VACCINE CONSENT FORM (This side for clinic use only)

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: _____

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