

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 This consent form is valid for up to 24 months unless consent is withdrawn verbally or in writing with Ottawa Public Health.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)	Tetanus, Diphtheria and Acellular Pertussis Vaccine (Tdap)
<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 (if needed, one dose).</p> <p><input type="checkbox"/> Yes Initials: _____</p> <p><input type="checkbox"/> No Initials: _____</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 (if needed, 2 or 3 doses depending on age).</p> <p><input type="checkbox"/> Yes Initials: _____</p> <p><input type="checkbox"/> No Initials: _____</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 vaccine (if needed, 2 or 3 doses depending on age).</p> <p><input type="checkbox"/> Yes Initials: _____</p> <p><input type="checkbox"/> No Initials: _____</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 tetanus, diphtheria, and acellular pertussis vaccine (if needed, one dose).</p> <p><input type="checkbox"/> Yes Initials: _____</p> <p><input type="checkbox"/> No Initials: _____</p>

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 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 <i>(Initial)</i>	Panorama Verified		Dose Number
		Correct Interval <i>(Initial)</i>	Requires Dose <i>(Initial)</i>	
<input type="checkbox"/> Men-C-ACYW-135				_ / 1
<input type="checkbox"/> HB				_ / _
<input type="checkbox"/> HPV				_ / _
<input type="checkbox"/> Tdap				_ / _

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®	Engerix®-B Recombivax®	Gardasil®9	Adacel® Boostrix®
_____	_____	_____	_____
Lot Number	Lot Number	Lot Number	Lot Number
Diluent (Nimenrix® only)			
Dosage and Route: <input type="checkbox"/> 0.5ml Intramuscular	Dosage and Route: <input type="checkbox"/> 1.0ml Intramuscular <input type="checkbox"/> 0.5ml Intramuscular	Dosage and Route: <input type="checkbox"/> 0.5ml Intramuscular	Dosage and Route: <input type="checkbox"/> 0.5ml Intramuscular
Site: <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid	Site: <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid	Site: <input type="checkbox"/> Left Deltoid <input type="checkbox"/> Right Deltoid	Site: <input type="checkbox"/> Left Deltoid <input type="checkbox"/> 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: _____