

# School Clinic Vaccine Consent Form 2019-2020

Student's Last Name: \_\_\_\_\_ Student's First Name: \_\_\_\_\_

School: \_\_\_\_\_ Class: \_\_\_\_\_ Date of Birth (Y/M/D): \_\_\_\_\_

Answer the four questions about your child's health history. If you answer "yes" to one of them, briefly describe.

- |   |  |
|---|--|
| 1. Does the student have a serious medical condition?       | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ |
| 2. Has the student ever had a reaction(s) to any vaccines?  | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ |
| 3. Does the student have a history of fainting or seizures? | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ |
| 4. Does the student have any allergies?                     | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ |

Parent/Guardian's Name (Print): \_\_\_\_\_ Tel.: \_\_\_\_\_

Parent/Guardian's Name (Print): \_\_\_\_\_ Tel.: \_\_\_\_\_

**Please indicate your consent "YES" or "NO" 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 This consent form is valid for up to 24 months unless consent is withdrawn verbally or in writing with Ottawa Public Health.**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 (one dose).

**Yes**  
 Parent/Guardian's Signature: \_\_\_\_\_  
 Student Signature: \_\_\_\_\_  
 Date: Y/M/D \_\_\_\_\_

**No.** Do not vaccinate my child.  
 My child has already received Menactra®, Menveo® or Nimenrix® on: Date: Y/M/D \_\_\_\_\_  
 Parent/Guardian's Signature: \_\_\_\_\_  
 Date: Y/M/D \_\_\_\_\_

## Hepatitis B Vaccine

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).

**Yes**  
 Parent /Guardian's Signature: \_\_\_\_\_  
 Student Signature: \_\_\_\_\_  
 Date: Y/M/D \_\_\_\_\_

**No.** Do not vaccinate my child.  
 Parent /Guardian's Signature: \_\_\_\_\_  
 Date: Y/M/D \_\_\_\_\_

## Human Papillomavirus Vaccine

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 or 3 doses depending upon my age).

**Yes**  
 Parent /Guardian's Signature: \_\_\_\_\_  
 Student Signature: \_\_\_\_\_  
 Date: Y/M/D \_\_\_\_\_

**No.** Do not vaccinate my child.  
 Parent /Guardian's Signature: \_\_\_\_\_  
 Date: Y/M/D \_\_\_\_\_

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](mailto:Immunization@ottawa.ca) or visit the Information Practice Statement of the Medical Officer of Health at: <https://ottawa.ca/en/city-hall/your-city-government/policies-and-administrative-structure/freedom-information-and-1#information-practice-statement>