Services de santé du TIMISKAMING Health Unit

SCHOOL IMMUNIZATION CONSENT

1. STUDENT INFORMATION (please print)

Legal Last Name	Legal First Name	◯ Male	◯ Female	◯ Other
Birthday yyyy/mm/dd	School	Class or Teacher's Name		
Parent / Legal Guardian Name	Relationship to Student	Home Phone:	Work or Cell:	

2. STUDENT IMMUNIZATION

My child has **already received** the following: *(circle trade name & provide dates vaccines were given)*

◯ hepatitis B vaccine
Engerix®-B / Recombivax-HB®

dates: _____ yyyy/mm/dd _____ yyyy/mm/dd _____ yyyy/mm/dd

◯ meningococcal-ACYW-135 vaccine
Menactra®/ Menveo™/ Nimenrix®

date: _____ yyyy/mm/dd

◯ combination hepatitis A & B vaccine
Twinrix® Jr. / Twinrix®

dates: _____ yyyy/mm/dd _____ yyyy/mm/dd _____ yyyy/mm/dd

◯ human papillomavirus vaccine
Gardasil® / Gardasil®9 / Cervarix®

dates: _____ yyyy/mm/dd _____ yyyy/mm/dd _____ yyyy/mm/dd

◯ Covid-19 vaccine
Pfizer

dates: _____ yyyy/mm/dd _____ yyyy/mm/dd

◯ Tdap vaccine- Adacel
Tetanus/ Diptheria/ Pertussis

date: _____ yyyy/mm/dd

3. STUDENT HEALTH HISTORY

			If "yes," explain
a)	Is your child allergic to yeast, alum, latex, diphtheria toxoid protein, other?	❍ Yes ❍ No	
b)	Has your child ever had a reaction to a vaccine?	❍ Yes ❍ No	
c)	Does your child have a history of fainting?	❍ Yes ❍ No	
d)	Does your child have a serious medical condition?	❍ Yes ❍ No	
e)	Does your child have a weak immune system or taking a medication that increases the risk of infection? (e.g. corticosteroids)	❍ Yes ❍ No	
f)	Have you received a vaccine in the last 14 days?	❍ Yes ❍ No	
g)	Do you have a bleeding disorder or are you taking blood thinning medications?	❍ Yes ❍ No	

4. CONSENT FOR VACCINATION

I have read the attached immunization vaccine fact sheets. I understand the expected benefits and possible risks and side effects of the vaccines. I understand the possible risks to my child if not vaccinated. I have had the opportunity to have my questions answered by the Timiskaming Health Unit. This consent is valid for two years. I understand that I can withdraw my consent at any time.

INDICATE YOUR CONSENT BY CHECKING YES OR NO FOR EACH VACCINE AND SIGN:

☐ **YES**	I authorize the Timiskaming Health Unit to administer **one dose of meningococcal-ACYW-135* vaccine** to my child. (Ages 12+)
☐ **NO**	I do not authorize the Timiskaming Health Unit to vaccinate my child with meningococcal* vaccine.
	***This vaccine is required for school attendance.**
☐ **YES**	I authorize the Timiskaming Health Unit to administer two doses of human papillomavirus vaccine (Gardasil®9) to my child to be given at least six months apart.
☐ **NO**	I do not authorize Timiskaming Health Unit to vaccinate my child with human papillomavirus vaccine.
☐ **YES**	I authorize the Timiskaming Health Unit to administer **two doses of hepatitis B vaccine** to my child to be given at least six months apart.
☐ **NO**	I do not authorize the Timiskaming Health Unit to vaccinate my child with hepatitis B vaccine.

X _____ _____

Signature of Parent ☐ **or Legal Guardian** ☐ **Date**

TIMISKAMING HEALTH UNIT USE ONLY (Checklist to assist with assessment. Use vaccine administration section only if unable to record in Panorama)

1. **Use 2 client identifiers**
2. **HPV 2-dose schedule**: is there a minimum of 168 days since dose one?
3. **Hepatitis B 2-dose schedule**: is there a minimum of 168 days since dose one?
4. **Pfizer 2-dose schedule** : is there a minimum of 21 days since dose one?
5. Has student received hepatitis B, HPV, meningococcal or Pfizer vaccine from another health care provider?
6. Does student understand what the vaccine(s) are for?
7. Does student verify if they have ever had a reaction to a vaccine?
8. Inquire if student has any allergies.
9. Inquire if anything changed with students health recently.
10. Inquire if student has a fever today.
11. Inquire if student thinks they might be pregnant?

MENINGOCOCCAL-ACYW-135 VACCINE (Menactra®)

- ○ **Menactra® 0.5 mL**
- ○ **Menveo™ 0.5 mL**
- ○ **Nimenrix® 0.5 mL**

TIME _____

DATE _____

IM DELTOID: Left Right

LOT # _____

SIGNATURE:

Panorama entered by:

Tdap (Adacel®)

○ **Adacel 0.5 mL**

DATE _____

TIME _____

LOT # _____

IM DELTOID: Left Right

SIGNATURE:

Panorama entered by:

HUMAN PAPILLOMAVIRUS VACCINE (Gardasil®9)

○ **Dose 1: 0.5 mL**

DATE _____

TIME _____

LOT # _____ IM DELTOID: Left Right

SIGNATURE:

Panorama entered by:

○ **Dose 2: 0.5 mL**

DATE _____

TIME _____

LOT # _____ IM DELTOID: Left Right

SIGNATURE:

Panorama entered by:

HEPATITIS B VACCINE

Dose 1

- ○ **Engerix®-B 1.0mL / 0.5mL IM**
- ○ **Recombivax HB® 1.0mL / 0.5mL IM**

DATE _____

TIME _____

LOT # _____

DELTOID: Left Right

SIGNATURE:

Panorama entered by:

Dose 2

- ○ **Engerix®-B 1.0mL / 0.5mL IM**
- ○ **Recombivax HB® 1.0mL / 0.5mL IM**

DATE _____

TIME _____

LOT # _____

DELTOID: Left Right

SIGNATURE:

Panorama entered by:

The information provided or attached to this form is being collected, and will be used by, Timiskaming Health Unit (THU) for the purpose of the Medical Officer of Health maintaining an immunization record on the above named student and to take appropriate action to prevent certain vaccine preventable diseases. THU will enter your child's immunization information into a secure provincial immunization database called Panorama. Your child's immunization information may be shared with or accessed by another health care provider for the purpose of providing care to you or your dependent, and otherwise as required or permitted by law. If you do not want this information shared please provide notification to the address provided. If you have questions about the privacy of your child's immunization information, please contact us at 43-247 Whitewood Avenue P.O Box 1090 New Liskeard, ON P0J 1P0.