BUREAU DE SANTÉ DE MIDDLESEX-LONDON HEALTH UNIT
www.healthunit.com

GRADE 7 IMMUNIZATION CONSENT FORM

Vaccine Preventable Disease Program

Fill in ALL shaded areas of this form, sign and return it to the school prior to the clinic date.

Last Name	First Name	Ontario Health Card Number
Date of Birth (Year/Month/Day)	School	Teacher Name
Gender (Circle one) Male Female Other	Parent / Legal Guardian Name	Parent Phone Number (Daytime)

Is the student allergic to: yeast, latex, thimerosal, tromethamine or diphtheria/ tetanus toxoid?	YES	NO	
Has the student ever had a serious reaction to a vaccine?	YES	NO	
Does the student have a history of fainting or seizures?	YES	NO	
Does the student have a bleeding disorder?	YES	NO	
Is the student pregnant?	YES	NO	
Is the student immunocompromised?	YES	NO	

A signature for consent is required by the parent / legal guardian for each type of vaccine below

Consent: I am the parent or legal guardian of the above-named student, I have read the provided fact sheet for the vaccines and understand the expected benefits, possible risks and side effects. I have had the opportunity to ask questions and seek answers about the vaccine(s). I understand that Meningococcal ACYW-135 is mandatory for school attendance. This consent is valid until all doses are given and consent may be withdrawn at any time by contacting the Health Unit.

Please note: If the student has had previous doses of these vaccine(s), the nurse will determine if more doses are required, according to the Ontario Immunization Schedule and the Canadian Immunization Guide. If you sign on the line giving consent for that specific vaccine, you are consenting for any remaining doses to be given thereby finishing the series for optimal protection.

Meningococcal ACYW-135 Vaccine	Hepatitis B Vaccine	Human Papillomavirus Vaccine
I consent to Men-C-ACYW 135 vaccine: X_____ Print parent / legal guardian name X_____ Sign parent / legal guardian name Date:	**I consent to Hepatitis B vaccine:** X_____ Print parent / legal guardian name X_____ Sign parent / legal guardian name Date:	**I consent to HPV-9 vaccine:** X_____ Print parent / legal guardian name X_____ Sign parent / legal guardian name Date:
Previous doses given: (not including Men-C vaccine (Neis-Vac®, Menjugate®) _____ _____ _____ (Include exact date, Doctor's name and phone #)	**Previous doses given:** (including Twinrix Jr® and Twinrix® Adult – indicate dose) _____ _____ _____ (Include exact date, Doctor's name and phone #)	**Previous doses given:** _____ _____ _____ (Include exact date, Doctor's name and phone #)
Clinic use only:	**Clinic use only Dose #1:** Recombivax® / Engerix®	**Clinic use only Dose #1:**
Lot #:	Lot #:	Lot #:
Expiry Date:	Expiry Date:	Expiry Date:
Dose date:	Dose date:	Dose date:
Time given:	Time given:	Time given:
R del L del 1.5"	R del L del 1.5"	R del L del 1.5"
Nurse:	Nurse:	Nurse:

Complete after 1 dose: ○

Verbal consent: ○
Given by: _____
Relationship: _____
Given to: _____

Date: _____

Dose #2: Recombivax® / Engerix®	Dose #2
Lot #:	Lot #:
Expiry Date:	Expiry Date:
Dose date:	Dose date:
Time given:	Time given:

Personal information is collected under the authority of the Health Protection and Promotion Act R.S.O. 1990 (as amended), the Immunization of School Pupils Act, 1990, s.8 (as amended) and is used to maintain an immunization record on your child and take appropriate action to prevent certain vaccine preventable diseases. The immunization information is also used to monitor immunization status in the community. Should you have questions about the collection and maintenance of this information, please contact the Vaccine Preventable Disease Manager at 519 663-5317.

Nurse Assessment	Visit #1	Visit #2	Notes
Do you have a fever or are you sick today?	Y N	Y N	
Has anything changed with your health recently?	Y N	Y N	
Did you have a serious reaction to a vaccine before? (or last dose if on dose #2)	Y N	Y N	
Is it possible that you may be pregnant? (female students only)	Y N	Y N	
Do you understand what this vaccine(s) is for?	Y N	Y N	
Do you have any questions?	Y N	Y N	
Nurse Initials			

Men, HB, HPV-9 (circle)
Nurse: _____

R del L del 1.5”	R del L del 1.5”
Nurse:	Nurse:

Clinic Use:

Nursing Notes*:

_____
_____
_____
_____
_____
_____
_____

*Only to be used if Panorama is not available. All notes written here must be transferred to Panorama.
Check here if nurse wrote a note in Pan: ○

Reason student did not receive vaccine	Visit #1 Date stamp & initial		Visit #2 Date stamp & initial		Visit #3 Date stamp & initial	
Absent						
Refused						
Deferred						
Letter sent: reason other than above						
Moved (note location if known)						