Immunization Consent Form

Meningococcal (A, C, Y, W-135), Hepatitis B, and HPV9

Child's Information

Name:	
Date of Birth: day month year	
Address:	
Phone #:	Health Card #:

Parent/Legal Guradian's Name:
Daytime Phone #:
School:

Child's Health History:			
Does your child have any allergies?	No ☐	Yes ☐	If yes, please explain below
Has your child ever had an allergic reaction to a vaccine?	No ☐	Yes ☐	If yes, please explain below
Is your child allergic to any of the vaccine components? *(See Fact Sheet)*	No ☐	Yes ☐	If yes, please explain below
Does your child have any serious medical conditions?	No ☐	Yes ☐	If yes, please explain below
Does your child have a history of seizures, fainting, or asthma?	No ☐	Yes ☐	If yes, please explain below
Is your child taking any medication?	No ☐	Yes ☐	If yes, please explain below
Please explain any "Yes" answers:			

I have read or had explained to me the information about these vaccines. I have had the chance to ask questions, and understand the answers provided to me. I consent to my child receiving the vaccines indicated. I am aware that personal health information collected on this form may be released, when requested, to my physician or nurse practitioner, other health units, and other organizations as specified under the ***Personal Health Information Protection Act***. This is done to ensure that vaccines are administered at the right time and are not given more often than needed.

My child has already received the following: (please circle the trade name and provide dates given)	
☐ Meningococcal (A, C, Y, W-135) [Menactra / Menveo / Nimenrix] *(Menjugate given at 1 year of age is different from above)* Date: ____________	☐ Combination Hepatitis A & B [Twinrix Jr / Twinrix] Dates: ________ ________ ________
☐ Hepatitis B [Engerix-B / Recombivax-HB] Dates: ________ ________ ________	☐ Human Papillomavirus [Gardasil 4, 9 / Cervarix] Dates: ________ ________ ________

Meningococcal (A, C, Y, W-135)	Hepatitis B	Human Papillomavirus (HPV9)
☐ **Yes**, I authorize HPPH to vaccinate the above-named child with one dose of Meningococcal (A, C, Y, W-135) vaccine.	☐ **Yes**, I authorize HPPH to vaccinate the above-named child with two doses of Hepatitis B vaccine.	☐ **Yes**, I authorize HPPH to vaccinate the above-named child with two doses of HPV9 vaccine.
Parent/Legal Guardian Signature	Parent/Legal Guardian Signature	Parent/Legal Guardian Signature
Date	Date	Date
This vaccine is required for school attendance as per the Immunization of School Pupils Act.	☐ **No**, I do not consent that the above-named child be vaccinated against Hepatitis B.	☐ **No**, I do not consent that the above-named child be vaccinated against HPV9.
If you wish to exempt your child from this vaccination, please call HPPH at 1-888-221-2133.	Parent/Legal Guardian Signature	Parent/Legal Guardian Signature
	Date	Date

Unless cancelled, this request is valid for the time period required to complete the series.

This information is collected under the authority of the ***Health Protection and Promotion Act*** and the ***Immunization of School Pupils Act*** for the purpose of maintaining an immunization record for this student. For more information on this collection, contact the Public Health Manager at 1-888-221-2133.

For Health Unit Use Only - TO BE COMPLETED BY NURSE

Vaccine	Dose	Site	Nurse's Initials	Vaccine	Dose	Site	Nurse's Initials	Vaccine	Dose	Site	Nurse's Initials
☐ **Menactra** ☐ **Nimenrix**	0.5 mL IM	L or R Deltoid		**Dose #1** ☐ **Engerix-B** ☐ **Recombivax-HB**	1.0 mL IM	L or R Deltoid		**Dose #1 Gardasil 9**	0.5 mL IM	L or R Deltoid	
				Dose #2 ☐ **Engerix-B** ☐ **Recombivax-HB**	1.0 mL IM	L or R Deltoid		**Dose #2 Gardasil 9**	0.5 mL IM	L or R Deltoid	

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