Vaccine Consent for School Clinics

Leeds, Grenville & Lanark District HEALTH UNIT
Your Partner in Public Health
www.healthunit.org

Student's Last Name: _____ **Student's First Name**: _____

Date of Birth: (YYYY/MM/DD)_____ School:_____ Town:_____

Does your child have any conditions or take any medications that might affect their neurological or immune system (such as: unstable epilepsy, recent serious concussion, a bleeding disorder, cancer treatment, medications for Crohns disease, severe asthma)? ☐ NO ☐ YES

If yes details:_____

Parent/Guardian Phone Number: _____ Email address: _____

Has this student already received:

Meningococcal ACYW-135: Date Given:_____

Hepatitis B: Date Given:_____

HPV Vaccine: Date Given:_____

PARENT/GUARDIAN CONSENT

By signing below, I agree that:

I have read the information I was given on these vaccines.

I understand the benefits, risks and possible reactions of each vaccine.

The following consent is valid for the time needed to give all doses of the vaccines unless I cancel my consent.

MENINGOCOCCAL ACYW-135 (NIMENRIX/MENACTRA VACCINE)

☐ **YES, Please vaccinate my child with one dose of Nimenrix/Menactra vaccine (sign below)**

Name of Parent/Legal Guardian_____ Date_____

HEPATITIS B VACCINE (RECOMBIVAX HB/ENGERIX B VACCINE)

☐ **YES, Please vaccinate my child with two doses of Hepatitis B vaccine (sign below)**

Name of Parent/Legal Guardian_____ Date_____

HUMAN PAPILLOMA VIRUS – HPV (GARDASIL 9 VACCINE)

☐ **YES, Please vaccinate my child with two doses of Gardasil vaccine (sign below)**

Name of Parent/Legal Guardian_____ Date_____

For more information, call 1-800-660-5853
or visit www.healthunit.org