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: _____

If you have already received any of the below vaccines, please upload your records through our ICON site https://lgl.icon.ehealthontario.ca/#!/welcome

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 VACCINE)

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

Name of Parent/Legal Guardian_____ Date_____

HEPATITIS B VACCINE (ENGERIX B / RECOMBIVAX HB VACCINE)

☐ **YES, Please vaccinate my child with two (or three doses depending on age) of the 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 (or three doses depending on age) of Gardasil vaccine (sign below)**

Name of Parent/Legal Guardian_____ Date_____

TDAP (ADACEL VACCINE)

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

Name of Parent/Legal Guardian_____ Date_____

FOR PUBLIC HEALTH UNIT USE ONLY

MENINGOCOCCAL

Vaccine Dose (0.5ml)	Lot Number	Expiry Date	Site IM	Date Given	Time Given	Nurse Initials	Panorama Entered
NIMENRIX			L delt R delt				

HEPATITIS B

Vaccine Dose	(Engerix B/ Recombivax HB Vaccine)	Lot Number	Expiry Date	Site IM	Date Given	Time Given	Nurse Initials	Panorama Entered
Dose 1	Adults (1.0 ml)			L delt R delt				
	Ped (0.5ml)			L delt R delt				
Dose 2	Adults (1.0 ml)			L delt R delt				
	Ped (0.5ml)			L delt R delt				
Dose 3 *Only for 16-18	Ped (0.5ml)			L delt R delt				

HUMAN PAPILLOMA VIRUS – HPV

Vaccine	Gardasil 9	Lot Number	Expiry Date	Site IM	Date Given	Time Given	Nurse Initials	Panorama Entered
Dose 1	0.5 ml			L delt R delt				
Dose 2	0.5ml			L delt R delt				
Dose 3 *If ≥15	0.5ml			L delt R delt				

TDAP

Vaccine Dose (0.5ml)	Lot Number	Expiry Date	Site IM	Date Given	Time Given	Nurse Initials	Panorama Entered
ADACEL			L delt R delt				

NOTES: