

**1. STUDENT INFORMATION**

Last Name			First Name			Ontario Health Card #			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
									Male	Female	Other	
Birthday				School				Class or Teacher's Name				
Year	Month	Day										
Parent/Legal Guardian Name (please print)				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)

<input type="radio"/> hepatitis B vaccine Engerix®-B / Recombivax-HB® date _____ date _____ date _____ yyyy/mm/dd yyyy/mm/dd yyyy/mm/dd			<input type="radio"/> meningococcal-ACYW-135 vaccine Menactra®/ Menveo™/ Nimenrix® date _____ yyyy/mm/dd		
<input type="radio"/> combination hepatitis A & B vaccine Twinrix® Jr. / Twinrix® date _____ date _____ date _____ yyyy/mm/dd yyyy/mm/dd yyyy/mm/dd			<input type="radio"/> human papillomavirus vaccine Gardasil® or Cervarix® date _____ date _____ date _____ yyyy/mm/dd yyyy/mm/dd yyyy/mm/dd		

**3. STUDENT HEALTH HISTORY**

If "yes," explain

a) Is your child allergic to yeast, alum, latex, diphtheria toxoid protein, other?	<input type="radio"/> YES <input type="radio"/> NO	
b) Has your child ever had a reaction to a vaccine?	<input type="radio"/> YES <input type="radio"/> NO	
c) Does your child have a history of fainting?	<input type="radio"/> YES <input type="radio"/> NO	
d) Does your child have a serious medical condition?	<input type="radio"/> YES <input type="radio"/> NO	
e) Does your child have a weak immune system or taking a medication that increases the risk of infection? (e.g. corticosteroids)	<input type="radio"/> YES <input type="radio"/> 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 Toronto Public Health. This consent is valid for two years. I understand that I can withdraw my consent at any time. I understand that my child may receive up to three needles in one day.

**INDICATE YOUR CONSENT BY CIRCLING YES OR NO FOR EACH VACCINE**

<b>YES</b>	I authorize Toronto Public Health to administer <b>one dose of meningococcal-ACYW-135 vaccine</b> to my child. <b>This vaccine is required for school attendance.</b>
<b>NO</b>	I do not authorize Toronto Public Health to vaccinate my child with meningococcal vaccine.
<b>YES</b>	I authorize Toronto Public Health to administer <b>two doses of human papillomavirus vaccine</b> to my child to be given at least six months apart.
<b>NO</b>	I do not authorize Toronto Public Health to vaccinate my child with human papillomavirus vaccine.
<b>YES</b>	I authorize Toronto Public Health to administer <b>two doses of hepatitis B vaccine</b> to my child to be given at least six months apart.
<b>NO</b>	I do not authorize Toronto Public Health to vaccinate my child with hepatitis B vaccine.

X \_\_\_\_\_  
 Signature of Parent  or Legal Guardian  Date \_\_\_\_\_

**TORONTO PUBLIC HEALTH USE ONLY**

Student Name/Client ID \_\_\_\_\_

NURSE TO COMPLETE	DOSE 1	DOSE 2
1. HPV 2-dose schedule: is there a minimum of 168 days since dose one?	Not applicable	<input type="radio"/> YES <input type="radio"/> NO
2. Hepatitis B 2-dose schedule: is there a minimum of 168 days since dose one?	Not applicable	<input type="radio"/> YES <input type="radio"/> NO
3. Have you received hepatitis B, HPV or meningococcal vaccine from another health care provider?	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO
4. Do you understand what the vaccine(s) are for?	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO
6. Do you have any allergies?	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO
7. Has anything changed with your health recently?	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO
8. Do you have a fever today?	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO
9. Do you think you might be pregnant?	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO

MENINGOCOCCAL-ACYW-135 VACCINE (Menactra®)	
<b>Dose 0.5 mL</b> <input type="radio"/> vaccine self-loaded <input type="radio"/> vaccine loaded by _____ Signature _____	DATE _____ TIME _____ LOT # _____ IM DELTOID      Left      Right
Panorama entered by _____	

HUMAN PAPILLOMAVIRUS VACCINE (Gardasil®)	
<b>Dose 1: 0.5 mL</b> <input type="radio"/> vaccine self-loaded <input type="radio"/> vaccine loaded by _____ Signature _____ DATE _____ TIME _____ LOT # _____ IM DELTOID      Left      Right	<b>Dose 2: 0.5 mL</b> <input type="radio"/> vaccine self-loaded <input type="radio"/> vaccine loaded by _____ Signature _____ DATE _____ TIME _____ LOT # _____ IM DELTOID      Left      Right
Panorama entered by _____	Panorama entered by _____

HEPATITIS B VACCINE	
<b>Dose 1</b> <input type="radio"/> Engerix®-B 1.0mL / 0.5mL <input type="radio"/> Recombivax HB® 1.0mL / 0.5mL <input type="radio"/> vaccine self-loaded <input type="radio"/> vaccine loaded by _____ Signature _____ DATE _____ TIME _____ LOT # _____ IM DELTOID      Left      Right	<b>Dose 2</b> <input type="radio"/> Engerix®-B 1.0mL / 0.5mL <input type="radio"/> Recombivax HB® 1.0mL / 0.5mL <input type="radio"/> vaccine self-loaded <input type="radio"/> vaccine loaded by _____ Signature _____ DATE _____ TIME _____ LOT # _____ IM DELTOID      Left      Right
Panorama entered by _____	Panorama entered by _____

**NOTES**

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