simcoe muskoka
DISTRICT HEALTH UNIT

Consent for Human Papillomavirus Vaccine
Grade 8 Female *ONLY*

STEP 1 - STUDENT INFORMATION

Last Name	First Name	Ontario Health Card #	○ Female	○ Other
Birthdate yyyy/mm/dd	School		Class or Teacher's Name	
Name of Parent / Guardian	Relationship to Student	Home Phone	Work or Cell	

STEP 2 - STUDENT HEALTH HISTORY

			IF YES, PLEASE EXPLAIN
Do you have any allergies?	☐ Yes	☐ No	
Have you ever had an allergic reaction to a vaccine?	☐ Yes	☐ No	
Do you have a history of fainting or seizures?	☐ Yes	☐ No	
Do you have any serious medical conditions?	☐ Yes	☐ No	
Are you taking any medications?	☐ Yes	☐ No	
Is there a possibility you might be pregnant?	☐ Yes	☐ No	

Have you ever received Human Papillomavirus vaccine before? **IF YES, PLEASE INDICATE THE DATES**

Gardasil®			Cervarix®		
yyyy/mm/dd	yyyy/mm/dd	yyyy/mm/dd	yyyy/mm/dd	yyyy/mm/dd	yyyy/mm/dd

STEP 3 - PARENT/LEGAL GUARDIAN AWARENESS

The Health Care Consent Act states that all persons, regardless of age, may consent to medical treatment, provided they understand the benefits and risks of the treatment as well as the benefits and risks of not having the treatment. There is no minimum age in Ontario for informed consent. Students will be assessed by a nurse at the school clinic, based on the principles of the Health Care Consent Act, to ensure that informed consent can be obtained. Parents/Legal guardians are encouraged to talk with their children about the benefits/risks of immunization prior to the clinic. You can find more about the Health Care Consent Act at http://www.e-laws.gov.on.ca/

Parent / Guardian Signature:	**Date:** yyyy/mm/dd

STEP 4 – STUDENT CONSENT

I have read or had explained to me the information about the Human Papillomavirus vaccine. I understand the benefits, side effects and risks. Please circle **YES or NO.** Unless cancelled in writing, this consent is valid until the series is completed.

HPV vaccine series	
I want this vaccine ☐ **YES**	I do not want this vaccine ☐ **NO**
Student Signature:	Student Signature:
Date: yyyy/mm/dd	Date: yyyy/mm/dd

This information is being collected pursuant to the *Health Protection and Promotion Act*, R.S.O.1990, c.H.7 and will be retained, used, disclosed and disposed of in accordance with the *Municipal Freedom of Information and Protection of Privacy Act*, R.S.O.1990, c.M.56, the *Personal Health Information Protection Act,* 2004, S.O.c.3 and all applicable federal and provincial legislation and regulations governing the collection, retention, use, disclosure and disposal of information. This information may be shared with other health care providers.

PUBLIC HEALTH USE ONLY - TELEPHONE Parental Awareness					
Obtained from:	FOR:			Phone number called:	Date: yyyy/mm/dd
Relationship to student:	HPV	□ YES	□ NO	Nurse Signature:	Time:

NURSING INTERVENTIONS

PUBLIC HEALTH USE ONLY - Completed by nurse ONLY in the event of Panorama disruption i.e. connectivity						
	Dose	**Site**	**Lot Number**	**Date Administered**	**Time Administered**	**Administered By**
Gardasil® Vaccine	0.5mL IM	L or R Deltoid		yyyy/mm/dd		
	0.5mL IM	L or R Deltoid		yyyy/mm/dd		

PROGRESS NOTES

Date & Time	SOAIP	S – family / individual / group perception of problem O – nurses observations A – assessment I – intervention P – plan of action