simcoe muskoka
DISTRICT HEALTH UNIT

School Immunization Program

Consent for Human Papillomavirus Vaccine

STEP 1 - STUDENT INFORMATION

Student's Name: _____ Legal Surname _____ Legal First Name _____

☐ Male ☐ Female ☐ Other Birth Date: _____ yyyy/mm/dd

Address: _____ Number _____ Street _____ APT # _____ City / Town _____ Postal Code

Phone: _____ Daytime Phone: _____ Cell / Work

Ontario Health Card #: _____ Parent / Legal Guardian: _____

School: _____ Grade: _____ Teacher: _____

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 HPV vaccine before? ☐ Gardasil: _____ yyyy/mm/dd ☐ Cervarix: _____ 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:** _____

STEP 4 - 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:

Yes, I want this vaccine

Student Signature: _____

Date: _____

No, I do not want this vaccine

Student Signature: _____

Date: _____

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.

NURSING INTERVENTIONS

Health Unit Use Only – Completed by nurse ONLY in the event of Panorama disruption i.e. connectivity						
Gardasil® Vaccine	**Dose**	**Site**	**Lot Number**	**Date Administered**	**Time Administered**	**Administered By**
	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