

Tel: 705-721-7520 Toll free: 1-877-721-7520 www.simcoemuskokahealth.org Your Health Connection

CONSENT FOR GRADE 7 IMMUNIZATIONS

STEP 1 - STUDENT INFORMATION

Last Name	First Name	Ontario Health Card #	0	0	0
			Male	Female	Other
Birthdate yyyy/mm/dd	School		Class or ⁻	reacher's N	ame
Name of Parent / Guardian	Relationship to Student	Home Phone	Work or C	Cell	

STEP 2 - STUDENT IMMUNIZATION

My child has already received the following: (circle trade name & provide dates vaccines were given)

Hepatitis B vaccine				Meningococcal ACYW-135 vaccine			
○ Engerix®-B ○ Recombivax-HB®		IB®	O Menactra®		O Menveo™	O Nimerix®	
Dates				Dates			
Combination	on Hepatitis A & B	vaccine		Human Papillomavirus vaccine			
O Twinrix®	Jr.	O Twinrix®		O Gardasil	 ®	O Cerva	rix®
Dates				Dates			
STEP 3 - S	STUDENT HEALT	H HISTORY			IF "YI	ES" PLEASE EXPL	.AIN
Do you hav	e any allergies?		□ Yes	□ No			
Have you e	ver had an allergic i	eaction to a vaccine	? □ Yes	□ No			
Do you hav	e a history of faintin	g or seizures?	□ Yes	□ No			
Do you have any serious medical conditions? $\hfill\Box$		□ Yes	□ No				
Are you taking any medications?		□ Yes	□ No				
Is there a possibility you may be pregnant?		□ Yes	□ No				

STEP 4 - 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 principals 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:
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STEP 5 – STUDENT CONSENT I have read or had explained to me the information about Hepatitis B, Meningococcal and Human Papillomavirus (HPV) vaccines. I understand the benefits, side effects and risks. Please check **YES** or **NO** for <u>each</u> vaccine. Unless cancelled in writing, this consent is valid until the series is completed.

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		Hepati	tis B vac	cine (2 dose 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			
-	Human	Papillom	avirus (H	IPV) vaccine (2 dose 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		
-	Meningococcal ACYW-135 vaccine (single dose)						
NB: this vaccine is required for	r school atten	dance. Plea	ase contac	t Public Health for an exemption for	m if you do not want this vaccine		
I want this vaccine ☐ YES I do not want this vaccine ☐ NO							
Student Signature				Student Signature			
Date	yyyy/mm/dd			Date	yyyy/mm/dd		
PUBLIC HEALTH USE ONLY – Telephone Parental Awareness							
Obtained from:	FOR:			Phone number called:	Date:		
	HepB	□ YES	□ NO		yyyy/mm/dd		
Relationship to student:	HPV	□ YES	□ NO	Nurse Signature:	Time:		
T	Men ACYW-135	□ YES	□ NO				

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

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
Hepatitis B vaccine	1.0mL IM	Lt or Rt Deltoid		yyyy/mm/dd		
	1.0mL IM	Lt or Rt Deltoid		yyyy/mm/dd		
	Dose	Site	Lot Number	Date Administered	Time Administered	Administered By
HPV - Gardasil vaccine	0.5mL IM	Lt or Rt Deltoid		yyyy/mm/dd		
	0.5mL IM	Lt or Rt Deltoid		yyyy/mm/dd		
Meningococcal ACYW-135	Dose	Site	Lot Number	Date Administered	Time Administered	Administered By
vaccine	0.5mL IM	Lt or Rt 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