simcoe muskoka DISTRICT HEALTH UNIT
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*Your Health Connection*

# CONSENT FOR GRADE 7 IMMUNIZATIONS

## *STEP 1* - STUDENT INFORMATION

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

## *STEP 2* - STUDENT PREVIOUS IMMUNIZATION

**Student has already received the following: (*check trade name & provide dates vaccines were given*)**

| **Hepatitis B vaccine** | **Date(s) Given** | | |
|---|---|---|---|
| ○ Recombivax-HB® | yyyy/mm/dd | yyyy/mm/dd | yyyy/mm/dd |
| ○ Engerix®-B | yyyy/mm/dd | yyyy/mm/dd | yyyy/mm/dd |

| **Combination Hepatitis A & B vaccine** | **Date(s) Given** | | |
|---|---|---|---|
| ○ Twinrix® Jr. | yyyy/mm/dd | yyyy/mm/dd | yyyy/mm/dd |
| ○ Twinrix® | yyyy/mm/dd | yyyy/mm/dd | yyyy/mm/dd |

| **Meningococcal ACYW-135 vaccine** | **Date Given** |
|---|---|
| ○ Menveo™ | yyyy/mm/dd |
| ○ Nimerix® | yyyy/mm/dd |
| ○ Menactra® | yyyy/mm/dd |

| **Human Papillomavirus vaccine** | **Date(s) Given** | | |
|---|---|---|---|
| ○ Gardasil® | yyyy/mm/dd | yyyy/mm/dd | yyyy/mm/dd |
| ○ Cervarix® | yyyy/mm/dd | yyyy/mm/dd | yyyy/mm/dd |

## *STEP 3* - 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 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 principles of the Health Care Consent Act, to ensure that informed consent can be obtained. Parents/Legal guardians are encouraged to talk with their son/daughter 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 Print Name** **Signature:** **Date:**

## *STEP 5* - STUDENT CONSENT

I have read or had explained to me the information about Hepatitis B, Meningococcal ACYW-135 and Human Papillomavirus (HPV) vaccines. I understand the benefits, side effects and risks. Please check **YES** or **NO** for each vaccine.

### Hepatitis B vaccine (2 dose series)

□ **YES** I want this vaccine □ **NO** I do not want this vaccine

### Meningococcal ACYW-135 vaccine (single dose)

*This vaccine is required for school attendance under ISPA. Please contact Public Health for an exemption form if you do not want this vaccine.*

□ **YES** I want this vaccine □ **NO** I do not want this vaccine

### Human Papillomavirus (HPV) vaccine (2 dose series)

□ **YES** I want this vaccine □ **NO** I do not want this vaccine

## STUDENT SIGNATURE

Student Signature Date yyyy/mm/dd

**PUBLIC HEALTH USE ONLY – Telephone Parental Awareness**

| Obtained from: | FOR: | | | Phone number called: | Date: yyyy/mm/dd |
|---|---|---|---|---|---|
| | HepB | □ YES | □ NO | | |
| Relationship to student: | Men ACYW-135 | □ YES | □ NO | Nurse Signature: | Time: |
| | HPV | □ 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 | | | | | | |
|---|---|---|---|---|---|---|
| **Hepatitis B vaccine**<br>**Recombivax-HB® Engerix®-B** | **Dose** | **Site** | **Lot Number** | **Date Administered** | **Time Administered** | **Administered By** |
| | 1.0mL IM | Lt Deltoid | | yyyy/mm/dd | | |
| | 1.0mL IM | Lt Deltoid | | yyyy/mm/dd | | |
| | | | | | | |
| **Meningococcal ACYW-135 vaccine**<br>**Menactra®** | **Dose** | **Site** | **Lot Number** | **Date Administered** | **Time Administered** | **Administered By** |
| | 0.5mL IM | Rt Superior/Inferior Deltoid | | yyyy/mm/dd | | |
| | | | | | | |
| **HPV vaccine**<br>**Gardasil®9** | **Dose** | **Site** | **Lot Number** | **Date Administered** | **Time Administered** | **Administered By** |
| | 0.5mL IM | Rt Superior/Inferior Deltoid | | yyyy/mm/dd | | |
| | 0.5mL IM | Rt Superior/Inferior 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 |
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