

Menactra® A, C, Y, W-135 Meningococcal Immunization Consent Form

The Meningococcal vaccine is administered in one dose through a voluntary school based immunization program. Please read the attached Meningococcal information and if further information is required, call 625-5971 or visit TBDHU.COM

PLEASE COMPLETE AND RETURN THIS FORM TO YOUR CHILD'S SCHOOL.

Student's Last Name _____ First Name _____

Date of Birth (YY/MM/DD) _____ Age _____ Male Female

School _____ Grade _____

Parent/Guardian Contact Information (please print):

Name _____

Home () _____ Daytime Contact () _____

PLEASE CHECK ONE BOX ONLY AND SIGN BELOW:

Yes, please vaccinate my child with the Meningococcal Menactra® A, C, Y, W-135 vaccine.

I have read or had explained to me the attached information about the vaccine, benefits, side effects and risks of immunization. I am satisfied with the answers to my questions. Unless cancelled, this request is valid for the time needed to give the vaccine.

No, I do not consent to have the Meningococcal Menactra® A, C, Y, W-135 vaccine administered to my child.

X _____
Signature of parent/guardian/student Date

If any vaccine listed below has already been given, please provide the date.

Menomune® _____
Menactra® _____
Men AC® _____
Menjugate™/NeisVac-C™/Meningitec™ _____

NURSE USE ONLY

Vaccine: Menactra® A, C, Y, W-135 0.5 mL IM

Date _____ Time _____ Deltoid LT RT Nurse Signature _____

IMT-140 2011/07/19

Personal information on this form is collected under the authority of the *Health Protection and Promotion Act, R.S.O. 1990*, as amended and in accordance with the *Municipal Freedom of Information and Protection of Privacy Act, R.S.O. 1990* and the *Personal Health Information Protection Act, 2004*. This information will be used to maintain an immunization record. For questions regarding the collection of your personal information, please contact the Thunder Bay District Health Unit, 999 Balmoral Street, Thunder Bay, ON P7B 6E7. Telephone (807) 625-5900.

