

If "YES" explain

Vaccine Preventable Disease Program

1. STUDENT INFORMATION (please print) * Required information Last Name (Legal)* First Name (Legal)* Ontario Health Card Number* Preferred Name (Optional) Identifying Gender (Optional) Date of Birth* School* Class or Teacher's Name Month Day Year Parent / Legal Guardian Name* Relationship to Student* Home Phone* Work or Cell*

2. PREVIOUS STUDENT IMMUNIZATION

Has your child received the following vaccines? (please circle vaccine name & provide the dates given)			
Hepatitis B vaccine	Meningococcal-C-ACYW-135 vaccine		
Engerix [®] -B / Recombivax-HB [®]	Menactra [®] / Menveo™ / Nimenrix [®]		
Dates:	Date:		
Hepatitis A & B vaccine combination	Human Papillomavirus vaccine		
Twinrix [®] Jr. / Twinrix [®]	Gardasil® / Gardasil 9® / Cervarix®		
Dates:	Dates:		

3. STUDENT HEALTH HISTORY

a)	Is your child allergic to yeast, alum, latex, diphtheria toxoid protein, other?	OYES ONO	
b)	Has your child ever had a reaction to a vaccine?	OYES ONO	
c)	Does your child have a history of fainting?	OYES ONO	
d)	Does your child have a serious medical condition?	OYES ONO	
e)	Does your child have a weak immune system or takes a medication that increases the risk of infection? (e.g. corticosteroids)	OYES ONO	

4. CONSENT FOR VACCINATION

Indicate your consent by checking YES or NO for each vaccine - please sign & date bottom of consent

Meningococcal-C-ACYW-135 (Nimenrix [®] Vaccine) I authorize the Thunder Bay District Health Unit to administer one (1) dose of Meningococcal-C-ACYW-135 vaccine to my child at the school clinic. * Receiving a dose of Meningococcal-C-ACYW-135 vaccine is required to attend school in Ontario according to the Immunization of School Pupil's Act unless a valid legal exemption has been filed.	Oyes	O NO		
Hepatitis B (Recombivax-HB [®] / Engerix [®] B Vaccine)				
I authorize the Thunder Bay District Health Unit to administer two (2) doses of Hepatitis B vaccine to my child, given at least 6 months apart, at the school clinic.				
Human Papillomavirus-9 HPV (Gardasil-9 [®] Vaccine)	OYES			
I authorize the Thunder Bay District Health Unit to administer two (2) doses of Human Papillomavirus- 9 vaccine to my child given at least 6 months apart at the school clinic.				
I have read the attached immunization information. I understand the expected benefits, possible risks and side effects of the vaccines. I understand the possible risks to my child if not vaccinated. I have had the opportunity to have my questions answered by the Thunder Bay District Health Unit. This consent is valid for two years. I understand that I can withdraw my consent at any time. I understand that my child may receive up to three needles in one day.				
X				
Signature of Parent or Legal Guardian Date				

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 is used for screening, assessment, management, treatment and reporting purposes. 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

THUNDER BAY DISTRICT HEALTH UNIT USE ONLY

Meningococcal-C-ACYW-135 Vaccine (Nimenrix [®])				
Dose: 0.5mL				
Date:				
Hepatitis B Vaccine	Hepatitis B Vaccine			
Dose # 1	Dose # 2			
Engerix [®] -B 1.0mL / 0.5mL	O Engerix-®B 1.0mL / 0.5mL			
Recombivax HB [®] 1.0mL / 0.5mL	O Recombivax HB [®] 1.0mL / 0.5mL			
Date: Nurse Initial:	Date: Nurse Initial:			
Human Papillomavirus-9 Vaccine (Gardasil 9®)	Human Papillomavirus-9 Vaccine (Gardasil 9®)			
Dose # 1: 0.5mL	Dose # 2: 0.5mL			
Date: Nurse Initial:	Date: Nurse Initial:			