School Clinic Vaccine Consent Form – 2016/17

Student's Last Name:_____ **Student's First Name:**_____

School:_____ **Class:**_____ **Date of Birth** (Y/M/D)**:**_____

Does your child have any conditions or take any medications that might affect their neurological or immune system (such as: unstable epilepsy, recent serious concussion, a bleeding disorder, cancer treatment, medications for Crohns disease, severe asthma)? No ◯ Yes ◯
If yes details:_____

Parent/Guardian's Name:_____ **Tel.:**_____

Parent/Guardian's Name:_____ **Tel.:**_____

Please sign for EACH vaccine you want your child to get.

Meningococcal Vaccine

I have read the vaccine information sheet. I have had the chance to ask questions which were answered to my satisfaction. I understand the benefits and risks associated with this vaccine. I give consent to a nurse employed by Ottawa Public Health to administer the Meningococcal vaccine (one dose).

Parent Signature:_____ Student Signature:_____
Date:_____ Date:_____

* This consent form is valid for up to 24 months unless consent is withdrawn verbally or in writing with Ottawa Public Health.

Hepatitis B Vaccine

I have read the vaccine information sheet. I have had the chance to ask questions which were answered to my satisfaction. I understand the benefits and risks associated with this vaccine. I give consent to a nurse employed by Ottawa Public Health to administer the Hepatitis B vaccine (2 doses).

Parent Signature:_____ Student Signature:_____
Date:_____ Date:_____

* This consent form is valid for up to 24 months unless consent is withdrawn verbally or in writing with Ottawa Public Health.

Human Papillomavirus Vaccine

I have read the vaccine information sheet. I have had the chance to ask questions which were answered to my satisfaction. I understand the benefits and risks associated with this vaccine. I give consent to a nurse employed by Ottawa Public Health to administer the HPV vaccines (2 or 3 depending upon my age).

Parent Signature:_____ Student Signature:_____
Date:_____ Date:_____

* This consent form is valid for up to 24 months unless consent is withdrawn verbally or in writing with Ottawa Public Health.

Verbal Consent: Meningococcal Vaccine ☐ Hepatitis B Vaccine ☐ Human Papillomavirus Vaccine ☐
Received from_____ Date_____ RN/RPN_____

Personal Health Information is collected under the authority of Section 5 of the *Health Protection and Promotion Act* and will be used to administer vaccines including maintaining an immunization record for the vaccines. Questions regarding this collection and use of personal health information may be directed to the Supervisor, Vaccine Preventable Diseases, Ottawa Public Health by mail at 100 Constellation Drive, Ottawa, ON K2G 6J8, by telephone at 613-580-6744, or by e-mail at Immunization@ottawa.ca or visit the Information Practice Statement of the Medical Officer of Health at: http://ottawa.ca/en/city-hall/your-city-government/policies-and-administrative-structure/information-practice-statement

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