



Name of Client:		Date of Birth: YYYY/MM/DD	
Gender:	Ontario Health Card Number:	Age:	Grade:
Health Care Practitioner Location (HCP):		HCP Phone Number:	
		HCP Fax Number:	
Date of Request: YYYY/MM/DD		Date of scheduled appointment: YYYY/MM/DD	

\*For each vaccine being requested, please check all criteria(s) that apply for this client:

**Human Papillomavirus Vaccine Criteria (Gardasil 9 - 1 x 0.5 ml)**

Students (boys and girls) in 7 to 12

**Please note:**

- Clients who are < 15 when they receive their first dose, follow a **two dose schedule**
- Clients who are ≥ 15 when they receive their first dose, follow a **three dose schedule**

**Dose being requested:**     Dose 1         Dose 2         Dose 3

**Date previous doses administered:** Dose 1: YYYY / MM / DD        Dose 2: YYYY / MM / DD

**Meningococcal Vaccine Criteria**

Client must be registered and attending school in grades 7 to 12

**Hepatitis B Vaccine Criteria (Engerix B/Recombivax 1 x 1ml)**

Client must be registered and attending school in grade 7 to 12

**Please note:**

- Clients who are < 16 follow a **two dose schedule**
- Clients who are ≥ 16 follow a **three dose schedule (Pediatric Dose)**

**Dose being requested:**     Dose 1         Dose 2         Dose 3

**Date previous doses administered:** Dose 1: YYYY / MM / DD        Dose 2: YYYY / MM / DD

**Please note, you must complete and fax this form immediately to the North Bay Parry Sound District Health Unit at 705-474-0510 once the vaccine is administered.**

**Adverse Event Following Immunization (AEFI): Remember to report any AEFI's to the NBPSDHU**