North Bay Parry Sound District Health Unit
Bureau de santé du district de North Bay-Parry Sound

Client ID# _____

School Based Immunization Program Consent Form

Student's Last Name(s)	Student's First Name(s)	Date of Birth (YYYY/MM/DD)	☐ M ☐ F

Mailing Address	Apt/Unit #	PO Box #	City	Province	Postal Code

Daytime Phone #	Student's Ontario Health Card Number	School

Authority to consent for this student:

Name of person providing health assessment information and consent (please print):	
Relationship to student:	☐ Self ☐ Mother ☐ Father ☐ Grandparent ☐ Foster parent ☐ Other
Custody:	☐ Mother ☐ Father ☐ Shared ☐ Grandparent ☐ CAS ☐ Other

HEALTH ASSESSMENT – PLEASE ANSWER ALL OF THE QUESTIONS

Has your child ever had a reaction to a vaccine?	☐ No	☐ Yes
Does your child have any of the following allergies? ☐ No	☐ Neomycin ☐ Diphtheria ☐ Porcine Gelatin ☐ Egg ☐ Phenol Red	☐ Latex ☐ Thimerosal ☐ Yeast ☐ Polymyxin B ☐ Streptomycin
Does your child have any serious health problems? e.g. seizures, paralysis, bleeding disorder?	☐ No	☐ Yes
Does your child have a history of fainting?	☐ No	☐ Yes
Is your child taking any medication that may lower his/her immune system – such as cancer treatment?	☐ No	☐ Yes
Is your daughter pregnant?	☐ No	☐ Yes
Has your child received a tetanus immunization in the last 10 years. **If yes, please provide a copy of his/her immunization record.**	☐ No	☐ Yes
Has your child received any other vaccine(s) in the past month?	☐ No	☐ Yes

If you have any questions about these vaccines or require any further clarification of information before you make your decision, please contact one of our nurses at the Health Unit.
North Bay office – 1-800-563-2808 / 705-474-1400 ext 5252 Parry Sound Office - 1-800-563-2808 / 705-746-5801 ext 3215

CONSENT - PLEASE COMPLETE

I have read the relevant information sheets available on the Health Unit's website at www.myhealthunit.ca. I understand the benefits, risk and possible side effects from these vaccines. I understand I can withdraw my consent at any time by contacting the NBPSDHU. If my child has a serious adverse reaction to this vaccine, I will seek medical attention immediately and notify the NBPSDHU about the reaction.

Check "Yes" to the vaccine(s) that you consent for your child to receive:	
Tdap (tetanus, pertussis and diphtheria)	☐ Yes
Tdap-Polio (tetanus, pertussis, diphtheria and polio)	☐ Yes
Meningococcal conjugate A, C, Y, W-135	☐ Yes
MMR (measles, mumps and rubella)	☐ Yes
Polio	☐ Yes
☐ **I do not consent to my child receiving any of the above vaccines**	

Date: _____ Signature of Parent / Legal Guardian:_____

FOR NURSE'S USE ONLY
All vaccines administered under the authority of Dr. J. Chirico, following the Medical Directives:
VACCINE: ADACEL / BOOSTRIX DOSE: 0.5ML ROUTE: IM

MED-DIR Authority	Date and Time	Site	Lot Number	Nurse's signature
MED-VPD-014		Right / Left Deltoid		

VACCINE: ADACEL-POLIO / BOOSTRIX-POLIO DOSE 0.5ML ROUTE: IM

MED-DIR Authority	Date and Time	Site	Lot Number	Nurse's signature
MED-VPD-057		Right / Left Deltoid		

VACCINE: MENACTRA / MENVEO DOSE: 0.5ML ROUTE:IM

MED-DIR Authority	Date and Time	Site	Lot Number	Nurse's signature
MED-VPD-043		Right / Left Deltoid		

VACCINE: MMR II / PRIORIX DOSE: 0.5ML ROUTE:SC

MED-DIR Authority	Date and Time	Site	Lot Number	Nurse's signature
MED-VPD-011		Right / Left Arm		

VACCINE: IPV DOSE 0.5ML ROUTE: SC

MED-DIR Authority	Date and Time	Site	Lot Number	Nurse's signature
MED-VPD-004		Right / Left Arm		

"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. Any questions regarding this collection may be directed to the Personal Health Information Manager at the North Bay Parry Sound District Health Unit, 681 Commercial Street, North Bay, ON P1B 4E7 705-474-1400 / 1-800-563-2808 or at privacy@healthunit.ca."