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

1-800-563-2808
www.myhealthunit.ca

HEALTH UNIT REGISTRATION FORM FOR ATTENDANCE AT SCHOOL
Information and Instructions for Parents/Guardians

The North Bay Parry Sound District Health Unit is required by law (under the Immunization of School Pupils Act and the Immunization Management Protocol) to keep an immunization record on every child attending school in the district. The school assists us in this process by handing out the forms we need you to complete and returning them to us.

The Immunization of School Pupils Act and the Immunization Management Protocol provide for medical exemptions or conscience/religious belief affidavits. The completion of such forms is required if your child is unable to be vaccinated for medical reasons or if you object to having your child immunized. Copies of these forms can be obtained from the Health Unit, and the original documents must be completed and submitted to the Health Unit. Should you choose either option, you need to be aware that the Medical Officer of Health may order that your child be excluded from school. Exclusion would occur if there is an outbreak or immediate risk of an outbreak of a designated disease in the school at which your child attends and where satisfactory evidence of immunization or immunity has not been received.

A chart outlining the immunizations available to children in Ontario is provided below as a reference. All immunizations listed under the required immunizations are those your child must have up to date in order to attend school. The immunizations listed under the recommended immunizations are not required for attendance at school but are strongly recommended to ensure your child is protected against these diseases. As outlined in the Immunization of School Pupils Act, failure to provide this information may result in your child being suspended from school until the records are updated or until a medical exemption or conscience/religious belief affidavit is received at the North Bay Parry Sound District Health Unit.

Age at Vaccination	Required Immunizations					Recommended Immunizations					
	Diphtheria, Tetanus, Pertussis	**IPV** (Polio)	**MMR** (Measles, Mumps and Rubella)	**Meningo-coccal** (Meningitis)	**Varicella** (Chicken Pox) **If born in 2010 or after**	**Hib** (Haemophilus Influenza)	**Pneu-C** (Pneumonia)	**Rotavirus** (gastro-enteritis)	**Hep B**	**HPV**	**FLU**
2 months old	✓	✓				✓	✓	✓			
4 months old	✓	✓				✓	✓	✓			
6 months old	✓	✓				✓					
12 months old			✓	✓			✓				
15 months old					✓						
18 months old	✓	✓				✓					
4-6 years old	✓	✓	✓		✓						
Grade 7				✓ Menactra					✓	✓	
Teenage booster (due every 10 years)	✓										
Every year											✓

Vaccine Preventable Diseases Program

Programme des maladies pouvant être prévenues par la vaccination

345 Oak Street West
North Bay, ON P1B 2T2
Tel: (705) 474-1400 ext/poste 5252
Fax/Téléc: (705) 474-9399

70 Joseph Street, Unit 302
Parry Sound, ON P2A 2G5
Tel: (705) 746-5801 ext/poste 3215
Fax/Téléc: (705) 746-2711

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Client ID#_____

INSTRUCTIONS:	
1.	**Complete and sign the form below.**
2.	**Attach a copy of your child's immunization record.** *You may need to call your family doctor for a complete record – your doctor does not automatically send this information to us.*
3.	**Enclose the form and the immunization record in the attached envelope.**
4.	**Return the sealed envelope to the Health Unit.** You may mail the envelope directly to the Health Unit *(postage required)* or drop it off to our North Bay office at 345 Oak Street West or to our Parry Sound Office in the Parry Sound Mall. Alternatively, you may drop off the sealed envelope at the school (*they will send it to us by courier)*.
5.	**REMEMBER TO SEND US AN UPDATE EVERY TIME AN IMMUNIZATION IS RECEIVED.**

→ **ENTER NAME OF SCHOOL:**	**START DATE:**_____ **GRADE:**_____

Student's Legal Name (last)_____(first)_____ (middle)_____

Preferred Name if different from legal: (last)_____(first)_____

Gender: F / M Date of Birth: YY_____MM_____DD_____ Health Card #: _____

Student's Home Mailing Address:

Street # and Name: _____

Apt/Unit # _____ PO Box _____ RR#_____ Site _____

City/Town _____ Postal Code _____

Parent/Guardian Information:

Name: _____ Male: _____ Female: _____

Relationship to Student: _____ Home Phone: _____

Business Phone:_____ Ext. _____ Cell Phone:_____

Please check (√) the following: Guardian: _____ Custody: _____ Access to Records: _____

Name: _____ Male: _____ Female: _____

Relationship to Student: _____ Home Phone: _____

Business Phone:_____ Ext. _____ Cell Phone:_____

Please check (√) the following: Guardian: _____ Custody: _____ Access to Records: _____

Name of family doctor and telephone number: _____

I certify that the information provided on this form is accurate.

Parent/Guardian Signature: _____ Date: _____