Client ID#_____

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

Grade 7 School Immunization Program Consent Form

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

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

Daytime Phone #	Student's Ontario Health Card Number	School

Name of person providing health assessment information and consent (please print): _____

Custody: ☐ Parent ☐ Legal Guardian ☐ Grandparent ☐ CAS ☐ Other

CONSENT - PLEASE COMPLETE

Information about these vaccines are available on the Health Unit's website at www.myhealthunit.ca. I understand the benefits, risks and possible side effects from these vaccines. I understand this consent will remain in effect until all vaccines are received. I understand I can withdraw my consent at any time by contacting the NBPSDHU. If my child has a serious adverse reaction to any vaccine, I will seek medical attention immediately and notify the NBPSDHU about the reaction.

Hepatitis B (2 doses)	**(please √ yes or no for your consent)**	☐ **Yes**	☐ **No**
Human Papillomavirus - HPV (2 doses)	**(please √ yes or no for your consent)**	☐ **Yes**	☐ **No**
Meningococcal conjugate ACYW-135 (1 dose)	**(please √ yes or no for your consent)**	☐ **Yes**	☐ **No**

The Meningococcal conjugate ACYW-135 is a required vaccine under the Immunization of School Pupils Act for attendance at school. Students who do not provide proof of having received this vaccine or a valid exemption could be at risk of suspension from school.

Date: _____ Signature of Parent / Legal Guardian:_____

HEALTH ASSESSMENT – PLEASE ANSWER ALL OF THE QUESTIONS

Has your child ever had a reaction to a vaccine?	☐ Yes	☐ No
Does your child have any allergies to latex, thimerosal, yeast or diphtheria toxoid?	☐ Yes	☐ No
Does your child have any serious health problems? e.g. seizures, paralysis, bleeding disorder?	☐ Yes	☐ No
Does your child have a history of fainting?	☐ Yes	☐ No
Is your child taking any medication that may lower his/her immune system – such as cancer treatment?	☐ Yes	☐ No
Has your child previously received a dose of Hepatitis B vaccine? (i.e. Twinrix) **If yes, please provide a copy of his/her immunization record.**	☐ Yes	☐ No

If you have any questions about these vaccines or require any further clarification please contact one of our nurses at the Health Unit.
Email: vpd@healthunit.ca
North Bay Office – 1-800-563-2808 / 705-474-1400 ext 5252 - FAX: 705-474-9399
Parry Sound Office - 1-800-563-2808 / 705-746-5801 ext 3215 - FAX: 705-746-2711

FOR NURSE'S USE ONLY
All vaccines administered under the authority of Dr. J. Chirico

RECOMBIVAX HB® / ENGERIX B® DOSE: 1.0mL ROUTE: IM

MED-DIR Authority	Date and Time	Nurse's signature
MED-VPD-001		
MED-VPD-001		

GARDASIL 9 ® DOSE 0.5mL ROUTE: IM

MED-DIR Authority	Date and Time	Nurse's signature
MED-VPD-063		
MED-VPD-063		

MENACTRA® / MENVEO® DOSE: 0.5 mL ROUTE: IM

MED-DIR Authority	Date and Time	Nurse's signature
MED-VPD-043		

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