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 for HB and HPV Vaccines

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

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

Custody: ☐ Mother ☐ Father ☐ Shared ☐ 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 the series are completed. 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**

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 or yeast?	☐ 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
Is your daughter possibly pregnant?	☐ 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
Has your child previously received a dose of the HPV vaccine? **If yes, please provide a copy of his/her immunization record.**	☐ Yes	☐ No

If you have any questions about any of these vaccines or require further clarification 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

FOR NURSE'S USE ONLY

All vaccines administered under the authority of Dr. J. Chirico

VACCINE: RECOMBIVAX HB ® / ENGERIX B ® DOSE: 1.0ML ROUTE: IM

MED-DIR Authority	Date and Time	Site	Lot Number	Nurse's signature
MED-VPD-001		Right / Left Deltoid		
MED-VPD-001		Right / Left Deltoid		

VACCINE: GARDASIL 9 ® DOSE 0.5ML ROUTE: IM

MED-DIR Authority	Date and Time	Site	Lot Number	Nurse's signature
MED-VPD-063		Right / Left Deltoid		
MED-VPD-063		Right / Left Deltoid		

"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 ay Parry Sound District Health Unit, 345 Oak Street West, North Bay, ON P1B 2T2, 705-474-1400 / 1-800-563-2808 or at privacy@healthunit.ca."

August 2018