

This consent is for 3 different vaccines; Hepatitis B, Meningococcal ACYW-135 and Human Papillomavirus.

By completing this form you can:

1. Give permission for the student to get the vaccine
OR
2. Make sure we know you do not want the student to get the vaccine



Hepatitis B & Meningococcal ACYW-135 & Human Papillomavirus (HPV) Vaccines Consent Form

PART 1 STUDENT INFORMATION			
LAST NAME		FIRST NAME	GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER
BIRTH DATE YYYY/MM/DD	AGE	NAME OF GRADE 7 SCHOOL	
ADDRESS		CITY	POSTAL CODE
DAYTIME PHONE NUMBER		HOME PHONE NUMBER	HEALTH CARD NUMBER

Please give the best phone number Peel Health can reach you at; if we have questions

PART 2 IMMUNIZATION HISTORY		
<p>Your child may not require all the Hepatitis B, HPV and/or Meningococcal ACYW135 vaccines if they have received them in the past. If they have received these vaccinations, it is important for the Nurse to know in order to assess your child's immunization history. Fill in the spaces below <u>or</u> attach a copy of your child's yellow card to this consent.</p> <p>If your child has <u>not</u> received any of these vaccines in the past, please proceed to PART 3.</p>		
Meningococcal ACYW-135 <small>This vaccine is required for all students in grade 7 attending school.</small>	<input type="checkbox"/> Menactra [®] <input type="checkbox"/> Menveo [®] <input type="checkbox"/> Nimenrix [®]	Dose Received On: YYYY/MM/DD <small>Note: An additional dose is recommended if they received a dose over 5 years ago.</small>
Hepatitis B or Combination Hepatitis A+B	<input type="checkbox"/> Engerix [®] <input type="checkbox"/> Twinrix [®] <input type="checkbox"/> Recombivax [®] <input type="checkbox"/> Twinrix [®] Jr	Dose 1: YYYY/MM/DD Dose 2: YYYY/MM/DD Dose 3: YYYY/MM/DD
Human Papillomavirus	<input type="checkbox"/> Gardasil [®] <input type="checkbox"/> Cervarix [®]	Dose 1: YYYY/MM/DD Dose 2: YYYY/MM/DD Dose 3: YYYY/MM/DD

Please give the dates that each vaccine was given. If you are unsure you can contact your doctor or check your yellow Immunization Card

If you got the vaccine at a school or public health clinic in Ontario, you don't need to tell us. It will already be in our records.

PART 3 CONSENT FOR IMMUNIZATION		
<p>I have read the attached fact sheet. I understand the expected benefits and possible risks and side effects of the vaccines. I have had the opportunity to have my questions answered by Peel Public Health.</p>		
Please choose YES or NO for each of the following vaccines listed:	YES <small>I authorize Peel Public Health to immunize my child. I understand that I can withdraw my consent at any time.</small>	NO <small>I do not authorize Peel Public Health to immunize my child. I understand the possible risks to my child if not vaccinated.</small>
Meningococcal ACYW-135 <small>This vaccine is required for all students in grade 7 attending school.</small>	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Hepatitis B	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Human Papillomavirus	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<p>Parent/legal guardian signature is only required for those under 14 years of age. Individuals 14 years of age and older may sign their own consent. By signing below, I acknowledge and declare that the information provided in this consent form is true and accurate.</p>		
PRINTED NAME (Individual providing consent)	SIGNATURE	DATE YYYY/MM/DD
Relationship to individual being immunized	<input type="checkbox"/> Parent/Step-Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Sibling (over 18)	<input type="checkbox"/> Legal Guardian <input type="checkbox"/> Self (14+) <input type="checkbox"/> CAS worker

Students 13 years and younger require signature of parents/legal guardian or someone over 18 listed in this section

For each vaccine, please only check YES or NO. Not both.

By law only certain people can consent to be immunized

Notice with respect to the Collection of Personal Information:

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 all applicable municipal, federal, and provincial laws and regulations governing the collection, retention, use, disclosure and disposal of personal information including 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. 2004 c.3. This information will be used by Peel Public Health or an Ontario public health unit where your child attends school for the purposes of the administration and evaluation of the Vaccine Preventable Diseases Program. Any questions regarding this collection may be directed to the Medical Officer of Health, Peel Public Health, 7120 Hurontario Street, P.O. Box 667, RPO Streetsville, Mississauga, ON, L5M 2C2. 905-799-7700.

Peel Public Health will enter your child's immunization information into a secure provincial immunization database called Panorama. Your child's immunization information may be shared with or accessed by another health care provider if they administer immunizations or are required to maintain a record of immunizations for your child. If you do not want this information shared please provide notification to the address provided. If you have questions about the privacy of your child's immunization information, please contact Peel Public Health at 905-799-7700.

This is how the Region of Peel uses and protects the personal health information you give on this form