

Step 1. Student information

Last Name		First Name		Ontario Health Card #	Sex
Birthdate		School		Class or Teacher's Name	
Year	Month	Day			
Parent / Legal Guardian Name (please print)				Parent / Legal Guardian Phone	

Step 2. Student Vaccination History

If the student has already received the following vaccine(s), please circle the trade name and provide date the vaccine was given	Date vaccine was given		
	DOSE 1	DOSE 2	DOSE 3
1. Meningococcal-ACYW vaccine (special purchase e.g. for travel) Menactra® MenveoTM Nimenrix®	_____ yyyy/mm/dd		
2. Human papillomavirus (HPV) vaccine (2 or 3 dose series) Gardasil® Gardasil-9® Cervarix®	_____ yyyy/mm/dd	_____ yyyy/mm/dd	_____ yyyy/mm/dd
3. Hepatitis B (or combination) vaccine (2, 3 or 4 dose series) Engerix®-B Recombivax-HB® Twinrix®Jr Twinrix® INFANRIX-hexa®	_____ yyyy/mm/dd	_____ yyyy/mm/dd	_____ yyyy/mm/dd

Step 3. Health History

If "yes", explain

a) Is the student allergic to yeast, alum, latex, diphtheria or tetanus toxoid protein? Any other allergies?	<input type="radio"/> YES <input type="radio"/> NO	
b) Has the student ever had a reaction to a vaccine?	<input type="radio"/> YES <input type="radio"/> NO	
c) Does the student have a history of fainting?	<input type="radio"/> YES <input type="radio"/> NO	
d) Does the student have a serious medical condition?	<input type="radio"/> YES <input type="radio"/> NO	
e) Does the student have a weak immune system, or on a medication that weakens the immune system or increases the risk of infection?	<input type="radio"/> YES <input type="radio"/> NO	

Step 4. Consent for vaccination

I have read the attached vaccine information. I understand the expected benefits and possible risks and side effects of the vaccines. I understand the possible risks of not being vaccinated. I have had the opportunity to have my questions answered by Toronto Public Health. This consent is valid for two years. I understand that I can withdraw my consent at any time. I understand that three needles may be administered in one day.

YES I authorize Toronto Public Health to administer the following vaccines:

Check all the vaccines you give permission for the student to receive.

Note: Toronto Public Health will review the student's vaccination history (see Step 2) and vaccinate only if the student requires it.

meningococcal vaccine (1 dose)

human papillomavirus vaccine (2 or 3 doses)

hepatitis B vaccine (2 or 3 doses)

NO I do not authorize Toronto Public Health to administer the following vaccines to the student:

Check for each vaccine you do not want the student to receive:

meningococcal vaccine

human papillomavirus vaccine

hepatitis B vaccine

X _____ Parent Legal Guardian _____
Signature of Parent/Legal Guardian/Student Over 14 Years Old Relationship to Date

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NURSE TO COMPLETE	DOSE 1	DOSE 2
1. Has the student/parent consented to the meningococcal vaccine?	<input type="radio"/> YES <input type="radio"/> NO	Not Applicable
2. Has the student/parent consented to the human papillomavirus	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO
3. Has the student/parent consented to the hepatitis B vaccine?	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO
4. For HPV or Hep B, there is at least 168 days since the first dose.	Not Applicable	<input type="radio"/> YES <input type="radio"/> NO
5. Ensure the student understands why they are receiving the vaccine(s)	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO
6. Has the student received hepatitis B, HPV or meningococcal vaccine from another health care provider?	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO
7. Has the student ever had a reaction to a vaccine?	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO
8. Does the student have an allergy to yeast, alum, latex, diphtheria or tetanus toxoid protein?	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO
9. Does the student have a serious medical condition?	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO
10. Does the student have a fever today?	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO
11. Is the student pregnant?	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO

MENINGOCOCCAL-ACYW-135 VACCINE 0.5 mL dose	Intramuscular
One Dose Only: <input type="radio"/> Nimenrix® <input type="radio"/> Menveo™ <input type="radio"/> Menactra®	DATE _____
Vaccine loaded by <input type="radio"/> Self	TIME _____
<input type="radio"/> Other: _____	LOT # _____
SIGNATURE: _____	IM DELTOID Left Right
Panorama entered by: _____	

HUMAN PAPILLOMAVIRUS VACCINE Gardasil®9 0.5 mL dose	Intramuscular
Dose 1	Dose 2
Vaccine loaded by: <input type="radio"/> Self <input type="radio"/> Other: _____	Vaccine loaded by: <input type="radio"/> Self <input type="radio"/> Other: _____
DATE _____ TIME _____	DATE _____ TIME _____
LOT # _____ IM DELTOID Left Right	LOT # _____ IM DELTOID Left Right
SIGNATURE: _____	SIGNATURE: _____
Panorama entered by: _____	Panorama entered by: _____

HEPATITIS B VACCINE 0.5mL or 1.0mL dose	Intramuscular
Dose 1	Dose 2
<input type="radio"/> Engerix®-B 0.5mL <input type="radio"/> Engerix®-B 1.0mL	<input type="radio"/> Engerix®-B 0.5mL <input type="radio"/> Engerix®-B 1.0mL
<input type="radio"/> RecombivaxHB® 0.5mL <input type="radio"/> RecombivaxHB® 1.0mL	<input type="radio"/> RecombivaxHB® 0.5mL <input type="radio"/> RecombivaxHB® 1.0mL
Vaccine loaded by <input type="radio"/> Self <input type="radio"/> Other: _____	Vaccine loaded by <input type="radio"/> Self <input type="radio"/> Other: _____
DATE _____ TIME _____	DATE _____ TIME _____
LOT # _____ IM DELTOID Left Right	LOT # _____ IM DELTOID Left Right
SIGNATURE: _____	SIGNATURE: _____
Panorama entered by _____	Panorama entered by _____

NOTES
