



DT9246

## CONSENT TO VACCINATION AGAINST HEPATITIS A AND HUMAN PAPILLOMAVIRUS (HPV) FOR GRADE 4 STUDENTS

File number					
Child's last name					
Child's first name					
Date of birth		Year	Month	Day	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Health insurance number			Year	Month	Expiry date
Address (number, street)					
City				Postal code	

- Fill out all sections of the form including the box above using a pen
- Sign the form
- Detach the form from the pamphlet and return it quickly to the school, whether or not you consent to vaccination

Additional Identification					
Name of school					Class
Parent 1's name		Parent 2's name		Guardian's name (if applicable)	
Your relationship to the child: <input type="checkbox"/> Parent 1 <input type="checkbox"/> Parent 2 <input type="checkbox"/> Guardian			Phone number where you can be reached		Area code Number

Child's Medical and Vaccination Record	
1. Has your child ever had a serious allergic reaction that required emergency medical care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, state the cause: <input type="checkbox"/> Vaccine <input type="checkbox"/> Other, specify: _____	
2. Does your child have an immune system problem due to an illness (e.g., leukemia) or a medication he / she is taking (e.g., chemotherapy)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, your child needs to receive an extra dose.	
<b>Please provide your child's vaccination record upon request by the nurse, whether or not you consent to vaccination. This information, including the number of doses to be administered, will be verified and recorded.</b>	

Parent/Guardian Consent (Decision)			
As the parent or guardian of a child under the age of 14, you are in charge of vaccination decisions for this child.			
Explanations to help you make an informed decision are provided in the pamphlet attached to this form. If you would like additional information about vaccination programs, please contact your local CLSC or speak with the school nurse.			
Please read the following statements and check the box for each to give or decline consent. You must also sign your name at the bottom of the section. By giving your consent, you agree to the full vaccination series, which includes one dose of each vaccine listed below.			
<b>1. Indicate whether or not you consent to your child being vaccinated against hepatitis A.</b>			
[Grade 4 students will receive one dose of the hepatitis A vaccine. If your child has already been vaccinated against this disease, vaccine will only be administered if required].			
<input type="checkbox"/> I CONSENT to have my child vaccinated with this vaccine.			
<input type="checkbox"/> I DECLINE to have my child vaccinated with this vaccine.			
<input type="checkbox"/> DOES NOT APPLY – My child has already been vaccinated against hepatitis A or has already had hepatitis A.			
<b>2. Indicate whether or not your child may be vaccinated against HPV (human papillomavirus).</b>			
[Grade 4 students will receive one dose of the HPV vaccine, which protects against several types of HPV].			
<input type="checkbox"/> I CONSENT to have my child vaccinated with this vaccine.			
<input type="checkbox"/> I DECLINE to have my child vaccinated with this vaccine.			
<input type="checkbox"/> DOES NOT APPLY because my child has already been vaccinated against HPV.			
Parent's or guardian's signature		Date	Year Month Day

User's name	File number
-------------	-------------

SI-PMI ID no.
---------------

**TO BE COMPLETED BY PROFESSIONAL ADMINISTERING VACCINE**

VACCINATION DETAILS							
Vaccination Date (year, month, day)	Vaccination Time (00:00)	Vaccine Name	Batch #	Quantity/ Units	Administration Route	Injection Site	
					Intramuscular	Left arm	Right arm
					I.M.	<input type="checkbox"/>	<input type="checkbox"/>
					I.M.	<input type="checkbox"/>	<input type="checkbox"/>

**VACCINATION SITE:**

**INFORMATION ON HEALTH CARE PROFESSIONAL QUALIFIED TO VACCINATE**  
 Nurse     Physician     Respiratory Therapist     Midwife     Pharmacist

Name:	Signature:	Occupation (specify):	License #:
-------	------------	-----------------------	------------

**INFORMATION ON QUALIFIED CONTRIBUTOR ADMINISTERING VACCINE**  
 (To be completed only if vaccine is administered by a qualified contributor)

Name:	Signature:	Occupation (specify):	License #:
-------	------------	-----------------------	------------

Notes :

---



---



---



---