

INSTRUCTION SHEET FOR COMPLETING THE

School Immunization Consent Form

- 1 **READ** the information booklet you've been given about the vaccines and the diseases they prevent.
- 2 **TEAR OFF** this Instruction Sheet.
- 3 **COMPLETE** all parts of Sections 1 and 2 on the School Immunization Consent Form.
 - In **Section 1**, be sure to indicate whether your child has an allergy or has had a reaction to a vaccine.
 - If your child has ever received any of these vaccines, be sure to note the dates on which they received them in **Section 2**. This will help the nurse to determine which vaccines your child needs.
- 4 **SIGN and DATE** the bottom of Section 2.
- 5 **RETURN** the School Immunization Consent Form to your child's school.

Public Health may get in touch with you if they need more information. After your child has received ALL the vaccines you consented to, they will be provided with a record of their immunizations.

SIGN and RETURN the School Immunization Consent Form even if you **DO NOT** want your child to receive any of the vaccines.

WHEN IN DOUBT, ASK!

If you have any questions about immunization, or if there is anything you don't understand, contact your local Public Health office. You'll find contact information in your School Immunization Program booklet or online at www.nshealth.ca/public-health.

Return this consent form to your child's school. After your child has received ALL the vaccines you consented to, they will be provided with a record of their immunization. **Please complete in pen.**

School Immunization Consent Form

This consent form covers the Hepatitis B Vaccine; Human Papillomavirus (HPV 9) Vaccine; Meningococcal Quadrivalent Vaccine; and Tetanus, Diphtheria, and Acellular Pertussis (Tdap) Vaccine. Nova Scotia Health is committed to protecting the privacy of your personal health information, in accordance with the *Personal Health Information Act*. Aggregate immunization data is collected by Public Health and is used for reporting to support planning and management, and to assess coverage rates within Nova Scotia.

Complete Sections 1 and 2.

Section 1: STUDENT'S PERSONAL INFORMATION Grade: _____
 Full Name: _____ Address: _____
 Parent's/Guardian's Name: _____ Postal Code:
 Parent's Daytime Phone: _____ Parent's E-mail: _____
 Family Doctor's/Nurse Practitioner's Name: _____
 School Name: _____ Teacher's Name and Room Number: _____
 Health Card Number: - Date of Birth:
Year Month Day
 Does your child have an allergy or have they had a reaction to a vaccine?
 No Yes If Yes, please explain: _____

Section 2: PARENT/GUARDIAN CONSENT

- I have read the information I was given on these four vaccines. I understand the benefits, risks, and possible reactions of each vaccine.
- The consent given below is valid for the time needed to give all doses of the vaccines unless I cancel my consent in writing.
- By signing below, I give consent for the following vaccines to be given (check Yes or No for each of the vaccines) and for emergency treatment (e.g., epinephrine) to be provided, if required:**

Hepatitis B Vaccine (two doses)
 YES, I CONSENT NO, I DO NOT CONSENT
 If your child has already received Twinrix vaccine, please give the dates: Dose 1: _____ Dose 2: _____ Dose 3: _____
 If your child has already received Hepatitis B vaccine, please give the name of vaccine: _____
 and the dates: Dose 1: _____ Dose 2: _____ Dose 3: _____

Human Papillomavirus (HPV 9) Vaccine (two doses)
 YES, I CONSENT NO, I DO NOT CONSENT
 If your child has already received this vaccine, please give the name of vaccine: _____
 and the dates: Dose 1: _____ Dose 2: _____ Dose 3: _____

Meningococcal Quadrivalent Vaccine (one dose)
 YES, I CONSENT NO, I DO NOT CONSENT
 If your child has received this vaccine recently, please give the name of vaccine: _____ and the date: _____.

Tetanus, Diphtheria, and Acellular Pertussis (Tdap) Vaccine (one dose)
 YES, I CONSENT NO, I DO NOT CONSENT
 If your child has received this vaccine recently, please give the name of vaccine: _____ and the date: _____.

SIGNATURE REQUIRED
 Signature: _____ Print Name: _____ Date: _____
(Parent/Guardian) (Parent/Guardian)
 Public Health may get in touch with you if any other information is needed.

TO BE COMPLETED BY THE PUBLIC HEALTH NURSE OR LICENSED PRACTICAL NURSE

Hepatitis B Vaccine Vaccine Trade Name: _____
 1st Dose: _____ Site: Rt arm Lt arm Route: IM Lot # _____
 Time: _____ Date: _____ Signature: _____
 2nd Dose: _____ Site: Rt arm Lt arm Route: IM Lot # _____
 Time: _____ Date: _____ Signature: _____

Human Papillomavirus (HPV 9) Vaccine Vaccine Trade Name: _____
 1st Dose: _____ Site: Rt arm Lt arm Route: IM Lot # _____
 Time: _____ Date: _____ Signature: _____
 2nd Dose: _____ Site: Rt arm Lt arm Route: IM Lot # _____
 Time: _____ Date: _____ Signature: _____

Meningococcal Quadrivalent Vaccine Vaccine Trade Name: _____
 1 Dose: _____ Site: Rt arm Lt arm Route: IM Lot # _____
 Time: _____ Date: _____ Signature: _____

Tetanus, Diphtheria, and Acellular Pertussis (Tdap) Vaccine Vaccine Trade Name: _____
 1 Dose: _____ Site: Rt arm Lt arm Route: IM Lot # _____
 Time: _____ Date: _____ Signature: _____