Consent Form for School-Based Vaccines:

Meningococcal C-ACYW-135, Hepatitis B, Human Papillomavirus

1. Student Information (please print)		
Last Name	First Name	Preferred Name (if different) and Pronouns
Birthdate Year Month Day	School	Health Card Number
Parent/Legal Guardian Last Name	Parent/Legal Guardian First Name	Relationship to above named
Cell/Home phone	Work phone	Teacher

2. Student Health Information (please print)	Check YES or NO	If yes, please provide details
allergies to any of the vaccine components (refer to information sheet)	☐ YES ☐ NO	
a serious reaction to a previous vaccine	☐ YES ☐ NO	
a bleeding disorder	☐ YES ☐ NO	
a weakened immune system or taking a medication that increases the risk of infection (e.g., corticosteroids)	☐ YES ☐ NO	
history of fainting	☐ YES ☐ NO	
already received any of these vaccines (Note: The Meningococcal C-ACYW-135 vaccine is different from the Meningitis C vaccine that your child may have received as a baby. This one protects against four types of meningitis)	☐ YES ☐ NO	Meningococcal C-ACYW-135 **Date** Hepatitis B **Dates(s)** Human Papillomavirus **Date(s)**

3. Consent for Vaccination

I have read the school-based vaccines information sheet. I understand the benefits and side effects of the vaccines. I understand the possible risks to the above-named student if they are not vaccinated. This consent is valid for **two years**. I understand that I can withdraw my consent at any time as well as ask any questions by calling the health unit.

X_____	X_____
Signature of: ☐ **Parent** ☐ **Legal Guardian**	**Date (YYYY/MM/DD)**

I consent to the Lakelands Public Health giving the following vaccines to the above-named student:	Check YES or NO
Meningococcal C-ACYW-135 (required to attend school)	☐ YES ☐ NO
Hepatitis B	☐ YES ☐ NO
Human Papillomavirus	☐ YES ☐ NO

Personal and personal health information provided on this form is collected under the authority of the Health Protection and Promotion Act, Immunization of School Pupils Act and/or the Child Care and Early Years Act. The information is used to administer the Lakeland Public Health Vaccine Preventable Disease Program and will be handled in accordance with the Municipal Freedom of Information and Protection of Privacy Act and the Personal Health Information Protection Act. Questions about the collection, use and disclosure of this information may be directed to the Privacy Officer at 1-844-575-4567.

PLEASE RETURN COMPLETED CONSENT FORM TO THE SCHOOL

Haliburton Office
191 Highland Street, Unit 301
Haliburton, ON K0M 1S0

Lindsay Office
108 Angeline Street South,
Lindsay, ON, K9V 3L5

Peterborough Office
Jackson Square
185 King Street, Box 301
Peterborough, ON K9J 2R8

Port Hope Office
200 Rose Glen Road
Port Hope, ON L1A 3V6

Lakelands Public Health Use Only:

Meningococcal C-ACYW-135 Vaccine		
Date: _____ (YYYY/MM/DD)	IM Deltoid (L / R)	Nurse Initials: _____
Hepatitis B Vaccine		
Date: _____ (YYYY/MM/DD)	IM Deltoid (L / R)	Nurse Initials: _____
Date: _____ (YYYY/MM/DD)	IM Deltoid (L / R)	Nurse Initials: _____
Date: _____ (YYYY/MM/DD)	IM Deltoid (L / R)	Nurse Initials: _____
Human Papillomavirus Vaccine		
Date: _____ (YYYY/MM/DD)	IM Deltoid (L / R)	Nurse Initials: _____
Date: _____ (YYYY/MM/DD)	IM Deltoid (L / R)	Nurse Initials: _____
Date: _____ (YYYY/MM/DD)	IM Deltoid (L / R)	Nurse Initials: _____

Grade 7 - Round 1:	Grade 7 - Round 2:	Catch-Up 1:	Catch-Up 2:	Complete:

Client ID: