Consent Form for School-Based Vaccines:
Meningococcal C-ACYW-135,
Hepatitis B, Human Papillomavirus

Haliburton, Kawartha, Pine Ridge District Health Unit

Peterborough Public Health

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 Information (please print)	(Check YES or NO if the above named has/are:)	If yes, please provide details
allergies to any of the vaccine ingredients (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 vaccine 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.

Client ID: _____ (for health unit use only)

4. Sign and date

X_____

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

I consent to the HKNP Health Unit giving the following vaccines to the above-named student:	Check YES or NO	For health unit use only: Date given/Initials/Site
Meningococcal C-ACYW-135 (required to attend school)	☐ YES ☐ NO	
Hepatitis B	☐ YES ☐ NO	
Human Papillomavirus	☐ YES ☐ NO	

Gr 7 Round 1: **Gr 7 Round 2:** **Catch-Up 1:** **Catch-Up 2:** **Complete:**

We collect, use, and disclose your personal and personal health information under the authority of the Health Protection and Promotion Act, R.S.O. 1990, c.H.7, s.5, the Immunization of School Pupils Act (ISPA), R.S.O. 1990, s.11(1), and/or the Child Care and Early Years Act (CCEYA), S.O. 2014, s.35 and its Regulations. This information is collected for the purpose of assessing, keeping records, and reporting on the immunization status of children going to schools or enrolled in a licensed childcare program within the province of Ontario. Information collected is maintained electronically within a provincial immunization information system provided by the Ontario Ministry of Health. Information will be collected, used, and disclosed in accordance with the Personal Health Information Protection Act (PHIPA), 2004, S.O. 2004, c.3. Should you have any questions about this collection of information, please contact the Health Unit's Designated Privacy Officer, 200 Rose Glen Road, Port Hope, Ontario, L1A 3V6 or call 1-866-888-4577 x1515.

PLEASE RETURN COMPLETED CONSENT FORM TO THE SCHOOL

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

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

Port Hope Office
200 Rose Glen Road
Port Hope, ON L1A 3V5

Peterborough Office
185 King Street
Peterborough, ON K9J 2R8