Toronto Public Health

Vaccine Preventable Diseases Program

CONSENT FORM

Step 1. Student information

Last Name	First Name	Ontario Health Card #	Sex

Birthday			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® Gardisil-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?	◯ YES ◯ NO	
b)	Has the student ever had a reaction to a vaccine?	◯ YES ◯ NO	
c)	Does the student have a history of fainting?	◯ YES ◯ NO	
d)	Does the student have a serious medical condition?	◯ YES ◯ 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?	◯ YES ◯ NO	
f)	Has the student received a COVID-19 vaccine in the last 28 days?	◯ YES ◯ 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 Student**   **Date**

Fall 2021

TORONTO PUBLIC HEALTH USE ONLY

NURSE TO COMPLETE	DOSE 1	DOSE 2
1. Has the student/parent consented to the meningococcal vaccine?	◯ YES ◯ NO	**Not Applicable**
2. Has the student/parent consented to the human papillomavirus	◯ YES ◯ NO	◯ YES ◯ NO
3. Has the student/parent consented to the hepatitis B vaccine?	◯ YES ◯ NO	◯ YES ◯ NO
4. For HPV or Hep B, there is at least 168 days since the first dose.	**Not Applicable**	◯ YES ◯ NO
5. Ensure the student understands why they are receiving the vaccine(s)	◯ YES ◯ NO	◯ YES ◯ NO
6. Has the student received hepatitis B, HPV or meningococcal vaccine from another health care provider?	◯ YES ◯ NO	◯ YES ◯ NO
7. Has the student ever had a reaction to a vaccine?	◯ YES ◯ NO	◯ YES ◯ NO
8. Does the student have an allergy to yeast, alum, latex, diphtheria or tetanus toxoid protein?	◯ YES ◯ NO	◯ YES ◯ NO
9. Does the student have a serious medical condition?	◯ YES ◯ NO	◯ YES ◯ NO
10. Does the student have a fever today?	◯ YES ◯ NO	◯ YES ◯ NO
11. Is the student pregnant?	◯ YES ◯ NO	◯ YES ◯ NO
12. Has the student received a COVID-19 vaccine in the last 28 days?	◯ YES ◯ NO	◯ YES ◯ NO

MENINGOCOCCAL-ACYW-135 VACCINE   0.5 mL dose   Intramuscular

One Dose Only: ◯ Nimenrix® ◯ Menveo™ ◯ Menactra®

Vaccine loaded by ◯ Self

◯ Other:_____

==DATE==_____

==TIME==_____

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: ◯ Self ◯ Other: _____	Vaccine loaded by: ◯ Self ◯ 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   0.5 mL or 1.0 mL dose   Intramuscular

==Dose 1==	==Dose 2==
◯ Engerix®-B 0.5mL ◯ Engerix®-B 1.0mL ◯ Recombivax HB® 0.5mL ◯ Recombivax HB® 1.0mL	◯ Engerix®-B 0.5mL ◯ Engerix®-B 1.0mL ◯ Recombivax HB® 0.5mL ◯ Recombivax HB® 1.0mL
Vaccine loaded by ◯ Self ◯ Other: _____	Vaccine loaded by ◯ Self ◯ Other: _____
==DATE==_____ TIME _____	==DATE==_____ TIME _____
LOT #_____ ==IM DELTOID== Left Right	LOT #_____ ==IM DELTOID== Left Right
SIGNATURE: _____	SIGNATURE: _____
Panorama entered by	Panorama entered by

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