

CONSENT FOR SCHOOL IMMUNIZATIONS

IMPORTANT: COMPLETE AND RETURN THIS FORM TO THE SCHOOL *If you have any questions, please contact your local Health Unit – phone number*

CLIENT (CHILD / YOUTH) INFORMATION												
Last Name First Name		Prefe	erred Name	Birthdate (YYYY / MM /	DD) Personal Health Number (PHN)							
PARENT / GUARDIAN / REPRESENTATIVE SECTION												
For each question and immunization listed below, check Yes or No, then sign and date below.												
1. Has your child ever had a serious or life-threatening allergic reaction? ONO Yes (to what?)												
2. Is your child's immune system affected by a severe disease or medication? \bigcirc No \bigcirc Yes												
3. Has your child ever had lab-confirmed chickenpox disease or shingles? \bigcirc No \bigcirc Yes												
4. Do you identify your child as an Indigenous person?												
5. Do you have an immunization record that includes one or more doses of \bigcirc No \bigcirc Yes**												
the vaccine(s) indicated below?												
** If yes, please attach a copy of the record. We will review the record and only give immunizations that are still needed.												
Mature Minor Consent: Parents/guardians and representatives should make every effort to discuss the information in the HealthLinkBC												
File(s) for the vaccines listed below with the child, and to involve the child as much as possible in the decision to provide consent to												
immunization. Although a child may be immunized with the consent of a parent/guardian or representative, a child is entitled to be informed about immunization and may provide consent to immunization if the person administering the vaccine(s) is sure that the child												
understands the benefits of, ar												
Based on the BC Immunization Schedule and our records,			I understand the in	I understand the information in the HealthLinkBC File(s) for the vaccine(s)								
we recommend that your child be immunized for the			listed in this section. I understand the benefits and possible reactions for									
disease(s) listed below.				immunized. I understand that in								
I want my child immunized for:		es No		the rare occurrence of anaphylaxis, emergency treatment will be provided. I have had the opportunity to ask questions that were answered to my								
					s valid for two years for the vaccine							
		$\mathcal{O} \mid \mathcal{O}$	series listed in this section unless I cancel it.		•							
	(Print Name		Date (YYYY / MM / DD)							
			Signature		ndicate if you are the:							
			_		O Parent, or							
		C Legal Guardian, or										
			Driver and Country at March		· ·							
		$\supset \bigcirc$	Primary Contact Number		Secondary Contact Number							
			1									

PUBLIC HEALTH USE ONLY Immunization Date Administered Nurse Nurse's Site Route Dose # Lot # Administered (YYYY-MM-DD) Signature Notes \bigcirc LA \bigcirc RA \bigcirc LA ⊖ la \bigcirc LA \bigcirc RA \bigcirc LA \bigcirc RA OLA \bigcirc RA OLA \bigcirc RA ⊖ la \bigcirc RA Telephone Mature Minor **Telephone Consent** Mature Minor Consent

•			For:		1 1		1 1	
Telephone Consent Obtained From	Child Signature				No	Yes	No	
Relationship to Child				\bigcirc	\bigcirc	\bigcirc	\bigcirc	
Phone Number Called	Mature Minor ROI Sensitive Record Yes No			\bigcirc	\bigcirc	\bigcirc	\bigcirc	
				0	\bigcirc	0	\bigcirc	
Date (YYYY / MM / DD) Time O AM		Time O AM O PM		0	\bigcirc	0	\bigcirc	
Nurse Signature	Nurse Signature			0	0	0	\bigcirc	

Personal information collected on this form will be used by the health authority to update the student's immunization record. The information will be used and disclosed in accordance with the *Freedom of Information and Protection of Privacy Act*. Summary statistical information may be reported to the Ministry of Health. If you have any questions about the collection and use of this personal information, contact your local public health nurse. You may be contacted to request your participation in the evaluation of this school immunization program. HLTH 2398 2023/11/07