BRITISH COLUMBIA | Ministry of Health

CONSENT FOR GRADE 9 IMMUNIZATIONS

LAST NAME	FIRST NAME	SCHOOL	DIV / TEACHER

PREFERRED NAME	NAME OF PARENT / GUARDIAN / REPRESENTATIVE	RELATIONSHIP TO CHILD

BIRTHDATE (YYYY / MM / DD)	PERSONAL HEALTH NUMBER (PHN)	ALERT	HAS YOUR CHILD EVER HAD A SERIOUS OR LIFE-THREATENING ALLERGIC REACTION? ◯ NO ◯ YES (TO WHAT?):
PRIMARY CONTACT NUMBER	SECONDARY CONTACT NUMBER		IS YOUR CHILD'S IMMUNE SYSTEM AFFECTED BY A SEVERE DISEASE OR MEDICATION? ◯ NO ◯ YES

PARENT / GUARDIAN / REPRESENTATIVE – For the vaccines listed below, check Yes or No, sign and date.
I understand the information in the HealthLinkBC File for the vaccines listed below. I understand the benefits and possible reactions for each vaccine and the risk of not getting immunized. I understand that in the rare occurrence of anaphylaxis, emergency treatment will be provided. I have had the opportunity to ask questions that were answered to my satisfaction. I understand this consent is valid for two years for the vaccine(s) listed below unless I cancel it.

Mature Minor Consent: Parents/guardians and representatives should make every effort to discuss the information in the HealthLinkBC File 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, and possible reactions to, each vaccine, and the risk of not getting immunized.

PARENT / GUARDIAN / REPRESENTATIVE USE ONLY	PUBLIC HEALTH USE ONLY – CHILD'S IMMUNIZATION RECORD

Meningococcal Conjugate ACYW (Men-C-ACYW) Vaccine

Has your child received a dose of Meningococcal Conjugate ACYW vaccine (Menveo®, Menactra® or Nimenrix®) in grade 7 or later? If they have, give name of vaccine and date:

VACCINE	YYYY / MM / DD

I want my child immunized: ◯ **Yes** ◯ **No**

Signature	Date (YYYY / MM / DD)

	Date YYYY / MM / DD	SITE	LOT #	NURSE SIGNATURE
1 DOSE		◯ LA ◯ RA		

NURSE'S NOTES

Tetanus, Diphtheria, Pertussis (Tdap) Vaccine

If your child has had **a booster** dose of tetanus, diphtheria and pertussis combined vaccine (Tdap) at 10 years of age or older they **DO NOT** need the vaccine in grade 9. If they have, give date:

YYYY / MM / DD

I want my child immunized: ◯ **Yes** ◯ **No**

Signature	Date (YYYY / MM / DD)

	Date YYYY / MM / DD	SITE	LOT #	NURSE SIGNATURE
1 DOSE		◯ LA ◯ RA		

NURSE'S NOTES

PUBLIC HEALTH USE ONLY – MATURE MINOR CONSENT

I want to be immunized for Men-C-ACYW: ◯ **Yes** ◯ **No**

Child Signature:

I want to be immunized for Tdap: ◯ **Yes** ◯ **No**

Child Signature:

NURSE SIGNATURE

DATE (YYYY / MM / DD)

TIME ◯ AM ◯ PM

PUBLIC HEALTH USE ONLY – TELEPHONE CONSENT

TELEPHONE CONSENT OBTAINED FROM	FOR **Men-C-ACYW** ◯ **YES** ◯ **NO** **Tdap** ◯ **YES** ◯ **NO**	PHONE NUMBER CALLED	DATE (YYYY / MM / DD)
RELATIONSHIP TO CHILD		NURSE SIGNATURE	TIME ◯ AM ◯ PM

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.

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