



LAST NAME		FIRST NAME		SCHOOL		DIV / TEACHER	
GENDER <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (YYYY / MM / DD)		PERSONAL HEALTH NUMBER (PHN)		NAME OF PARENT / GUARDIAN / REPRESENTATIVE		RELATIONSHIP TO CHILD
HOME PHONE		CELL PHONE		ALERT			
ALTERNATE PHONE(S)							
				IS YOUR CHILD'S IMMUNE SYSTEM AFFECTED BY A SEVERE DISEASE OR MEDICATION? <input type="checkbox"/> NO <input type="checkbox"/> YES			

PARENT / GUARDIAN / REPRESENTATIVE – For each vaccine 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.

PARENT / GUARDIAN / REPRESENTATIVE USE ONLY		PUBLIC HEALTH USE ONLY – CHILD'S IMMUNIZATION RECORD			
Chickenpox (Varicella) vaccine					
If your child has had 2 doses of chickenpox vaccine after 1 year of age they DO NOT need this vaccine. If they have, please give dates:		Date YYYY / MM / DD	SITE	LOT #	NURSE SIGNATURE
1. YYYY / MM / DD	2. YYYY / MM / DD	1 ST DOSE	<input type="checkbox"/> LA <input type="checkbox"/> RA		
		2 ND DOSE	<input type="checkbox"/> LA <input type="checkbox"/> RA		
If your child has had chickenpox disease or shingles after 1 year of age and was diagnosed by a health care provider, they MAY NOT need this vaccine. If they have, at what age? _____ years		<input type="checkbox"/> Series Complete - no further doses required			
I want my child immunized: <input type="checkbox"/> Yes <input type="checkbox"/> No		NURSE'S NOTES			
Signature		Date (YYYY / MM / DD)			
Hepatitis B vaccine					
If your child has had 3 doses of hepatitis B vaccine they DO NOT need this vaccine. If they have, please give dates:		Date YYYY / MM / DD	SITE	LOT #	NURSE SIGNATURE
1. YYYY / MM / DD	2. YYYY / MM / DD	3. YYYY / MM / DD	1 ST DOSE	<input type="checkbox"/> LA <input type="checkbox"/> RA	
			2 ND DOSE	<input type="checkbox"/> LA <input type="checkbox"/> RA	
I want my child immunized: <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Series Complete - no further doses required			
Signature		NURSE'S NOTES			
Date (YYYY / MM / DD)					
Human Papillomavirus 9 (HPV9) vaccine					
If your child has had 2 or more doses of any HPV vaccine at least 6 months apart, they DO NOT need this vaccine. If they have, please give dates:		Date YYYY / MM / DD	SITE	LOT #	NURSE SIGNATURE
1. YYYY / MM / DD	2. YYYY / MM / DD	3. YYYY / MM / DD	1 ST DOSE	<input type="checkbox"/> LA <input type="checkbox"/> RA	
			2 ND DOSE	<input type="checkbox"/> LA <input type="checkbox"/> RA	
I want my child immunized: <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Series Complete - no further doses required			
Signature		NURSE'S NOTES			
Date (YYYY / MM / DD)					

PUBLIC HEALTH USE ONLY – TELEPHONE CONSENT			
TELEPHONE CONSENT OBTAINED FROM	FOR	PHONE NUMBER CALLED	DATE (YYYY / MM / DD)
RELATIONSHIP TO CHILD	CHICKENPOX <input type="checkbox"/> YES <input type="checkbox"/> NO	NURSE SIGNATURE	TIME <input type="checkbox"/> AM <input type="checkbox"/> PM
	HEPATITIS B <input type="checkbox"/> YES <input type="checkbox"/> NO		
	HPV9 <input type="checkbox"/> YES <input type="checkbox"/> NO		

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.