BRITISH COLUMBIA | Ministry of Health

CONSENT FOR GRADE 6 IMMUNIZATIONS

LAST NAME	FIRST NAME	SCHOOL	DIV / TEACHER

GENDER ☐ M ☐ F	BIRTHDATE (YYYY / MM / DD)	PERSONAL HEALTH NUMBER (PHN)	NAME OF PARENT / GUARDIAN / REPRESENTATIVE	RELATIONSHIP TO CHILD

HOME PHONE	CELL PHONE	ALERT	HAS YOUR CHILD EVER HAD A SERIOUS OR LIFE-THREATENING ALLERGIC REACTION? ☐ NO ☐ YES (TO WHAT?):
ALTERNATE PHONE(S)			IS YOUR CHILD'S IMMUNE SYSTEM AFFECTED BY A SEVERE DISEASE OR MEDICATION? ☐ NO ☐ 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.

Chickenpox (Varicella) vaccine

PARENT / GUARDIAN / REPRESENTATIVE USE ONLY

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:

1. YYYY / MM / DD	2. YYYY / MM / DD

Has your child ever had chickenpox disease or shingles?
☐ No ☐ Yes, at _____ years of age**
**If yes, was your child living in B.C. and seen by a health care provider?
☐ No ☐ Yes

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

Signature	Date (YYYY / MM / DD)

PUBLIC HEALTH USE ONLY – CHILD'S IMMUNIZATION RECORD

	Date YYYY / MM / DD	SITE	LOT #	NURSE SIGNATURE
1ST DOSE		☐ LA ☐ RA		
2ND DOSE		☐ LA ☐ RA		

☐ **Series Complete - no further doses required**
NURSE'S NOTES

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:

1. YYYY / MM / DD	2. YYYY / MM / DD	3. YYYY / MM / DD

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

Signature	Date (YYYY / MM / DD)

	Date YYYY / MM / DD	SITE	LOT #	NURSE SIGNATURE
1ST DOSE		☐ LA ☐ RA		
2ND DOSE		☐ LA ☐ RA		

☐ **Series Complete - no further doses required**
NURSE'S NOTES

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:

1. YYYY / MM / DD	2. YYYY / MM / DD	3. YYYY / MM / DD

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

Signature	Date (YYYY / MM / DD)

	Date YYYY / MM / DD	SITE	LOT #	NURSE SIGNATURE
1ST DOSE		☐ LA ☐ RA		
2ND DOSE		☐ LA ☐ RA		

☐ **Series Complete - no further doses required**
NURSE'S NOTES

PUBLIC HEALTH USE ONLY – TELEPHONE CONSENT

TELEPHONE CONSENT OBTAINED FROM	FOR	PHONE NUMBER CALLED	DATE (YYYY / MM / DD)
	CHICKENPOX ☐ YES ☐ NO **HEPATITIS B** ☐ YES ☐ NO **HPV9** ☐ YES ☐ NO		
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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PRINT RESET