



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	
HOME PHONE		CELL PHONE		ALERT HAS YOUR CHILD EVER HAD A SERIOUS OR LIFE-THREATENING ALLERGIC REACTION? <input type="checkbox"/> NO <input type="checkbox"/> YES (TO WHAT?):	
ALTERNATE PHONE(S)					

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 A-C-Y-W-135 (Men C-ACYW-135) Vaccine					
Has your child received a dose of Men-C-ACYW-135 vaccine (Menveo®, Menactra® or Nimenrix®) in grade 7 or later? If they have, give name of vaccine and date:		Date YYYY / MM / DD	SITE	LOT #	NURSE SIGNATURE
VACCINE	YYYY / MM / DD	1 DOSE	LA RA		
I want my child immunized. <input type="checkbox"/> Yes <input type="checkbox"/> No		NURSE'S NOTES			
Signature		Date (YYYY / MM / DD)			
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:		Date YYYY / MM / DD	SITE	LOT #	NURSE SIGNATURE
YYYY / MM / DD		1 DOSE	LA RA		
I want my child immunized. <input type="checkbox"/> Yes <input type="checkbox"/> No		NURSE'S NOTES			
Signature		Date (YYYY / MM / DD)			

PUBLIC HEALTH USE ONLY – MATURE MINOR CONSENT

I want to be immunized for Men-C-ACYW-135. <input type="checkbox"/> Yes <input type="checkbox"/> No	NURSE SIGNATURE	DATE (YYYY / MM / DD)
Child Signature:		
I want to be immunized for Tdap. <input type="checkbox"/> Yes <input type="checkbox"/> No		TIME
Child Signature:		<input type="checkbox"/> AM <input type="checkbox"/> PM

PUBLIC HEALTH USE ONLY – TELEPHONE CONSENT

TELEPHONE CONSENT OBTAINED FROM	FOR Men-C-ACYW-135 <input type="checkbox"/> YES <input type="checkbox"/> NO	PHONE NUMBER CALLED	DATE (YYYY / MM / DD)
RELATIONSHIP TO CHILD	Tdap <input type="checkbox"/> YES <input type="checkbox"/> NO	NURSE SIGNATURE	TIME <input type="checkbox"/> AM <input type="checkbox"/> 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.