**CONSENT FOR GRADE 7 IMMUNIZATIONS**

**Tetanus, Diphtheria and Pertussis (Tdap) VACCINE**

 **Human papillomavirus (HPV) VACCINE**

**PLEASE COMPLETE SECTIONS 1 AND 2**

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| **SECTION 1: STUDENT’S PERSONAL INFORMATION** |
| SCHOOL | GRADE | TEACHER (HOMEROOM) |
|  |  |  |
| LAST NAME | FIRST NAME | DATE OF BIRTH (YYYY / MM / DD) |
|  |  |  |  |  |
| GENDER | MEDICARE # | NAME OF PARENT / GUARDIAN |
| [ ]  M [ ]  F |  |  |
| DAYTIME PHONE (work or home) | OTHER DAYTIME PHONE  | PARENT’S / GUARDIAN’S EMAIL |
| [ ]  CELL | [ ]  CELL |  |
| **A****L****E****R****T** | DOES YOUR CHILD HAVE ALLERGIES? | [ ]  NO [ ]  YES\*  |  |
| \*IF YES, TO WHAT AND WHAT TYPE OF REACTION: |
| DOES YOUR CHILD HAVE A HEALTH PROBLEM? | [ ]  NO [ ]  YES\* |  |
| \*PLEASE EXPLAIN: |
| DOES YOUR CHILD TAKE ANY MEDICATIONS? | [ ]  NO [ ]  YES\* |  |
| \*PLEASE LIST: |
| **SECTION 2: PARENT / GUARDIAN CONSENT** |
| **For the two vaccines, check YES or NO, sign and date.**Your signature will confirm the following:* I have read the information I was given on the Human Papillomavirus (HPV) and the Tetanus, Diphtheria and Pertussis (Tdap) vaccines.
* I understand the benefits and possible reaction(s) for each vaccine and the risk of not getting immunized.

If you have any questions, please call your local Public Health office. |
| **Human Papillomavirus (HPV) Vaccine – 2 doses** |  | **Tetanus, Diphtheria & Pertussis (Tdap) Vaccine – 1 dose** |
| [ ]  YES, vaccinate my child. | Has your child received a dose of Tetanus, Diphtheria and Pertussis vaccine since January 2017?  **Date (YYYY / MM / DD)** |
| [ ]  NO, do not vaccinate my child.  | [ ]  NO [ ]  YES If yes, give the date |  |  |  |
|  | [ ]  YES, vaccinate my child. |
| If no, please specify:  | [ ]  NO, do not vaccinate my child.If no, please specify:  |
| **Signature of parent/guardian** | **Date (YYYY / MM / DD)** | **Signature of parent/guardian** | **Date (YYYY / MM / DD)** |
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**FOR PUBLIC HEALTH NURSE USE ONLY**

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| **SECTION 3: TO BE COMPLETED BY PUBLIC HEALTH NURSE** |
|  | **Lot #** | **Site** | **Route** | **Dosage** | **Date (YYYY/MM/DD)** | **Time** | **Signature** |
| **HPV** |  | [ ]  Right arm | [ ]  IM | [ ]  0.5 mL |  |  |  |
|  [ ]  GARDASIL 9 **DOSE 1** |  | [ ]  Left arm |  |  |  |  |  |
|  [ ]  GARDASIL 9 **DOSE 2** |  | [ ]  Right arm  | [ ]  IM | [ ]  0.5 mL |  |  |  |
|  | [ ]  Left arm |  |  |  |  |  |
| **Tdap** |  | [ ]  Right arm | [ ]  IM | [ ]  0.5 mL |  |  |  |
|  [ ]  ADACEL [ ]  BOOSTRIX |  | [ ]  Left arm |  |  |  |  |  |

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| **SECTION 4: PERSONAL IMMUNIZATION RECORD** |
| This section is to be completed by the Public Health nurse. **These immunization records will be given to your child after their immunization. Please keep these records with your child’s personal health files.** |
| **Tetanus, Diphtheria and Acellular Pertussis (Tdap) Vaccine** |  | **Human Papillomavirus (HPV) Vaccine – DOSE 1** |  | **Human Papillomavirus (HPV) Vaccine – DOSE 2** |
| STUDENT’S NAME |  | STUDENT’S NAME |  | STUDENT’S NAME |
|  |  |  |  |  |
| DOB (YYYY / MM / DD) |  | DOB (YYYY / MM / DD) |  | DOB (YYYY / MM / DD) |
|  |  |  |  |  |  |  |  |  |  |  |
| MEDICARE # |  | MEDICARE # |  | MEDICARE # |
|  |  |  |  |  |
| NAME OF VACCINE:[ ]  **ADACEL**[ ]  **BOOSTRIX** | DATE (YYYY / MM / DD) |  | NAME OF VACCINE:[ ]  **GARDASIL 9** | DATE (YYYY / MM / DD) |  | NAME OF VACCINE:[ ]  **GARDASIL 9** | DATE (YYYY / MM / DD) |
|  |  |  |  |  |  |  |  |  |  |  |
| TIME |  | TIME |  | TIME |
|  |  |  |  |  |
| NURSE’S SIGNATURE |  | NURSE’S SIGNATURE |  | NURSE’S SIGNATURE |
|  |  |  |  |  |

(August 2017)