** CONSENT FOR GRADE 9 IMMUNIZATIONS**

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 **MENINGOCOCCAL (Men A, C, Y, W-135) VACCINE**

 **VARICELLA (chickenpox) 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 Meningococcal and the Varicella 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. |
| **Meningococcal (A, C, Y, W-135) Vaccine – 1 dose** |  | **Varicella (chickenpox) Vaccine – 1 dose** |
| **Please note:**  This vaccine is recommended even if your child received a vaccine against meningococcal type C disease (NeisVac-C or Menjugate vaccine) in the past (around the age of 12 months). | Your child should have received one dose of this vaccine as a baby (around the age of 12 months).  **Date (YYYY / MM / DD)** |
| Please give the date of this dose: |  |  |  |
| [ ]  YES, vaccinate my child. | [ ]  YES, vaccinate my child. |
| [ ]  NO, do not 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** |
| **Meningococcal Quad (A,C,Y,W-135)** |  | [ ]  Right arm[ ]  Left arm | [ ]  IM | [ ]  0.5 mL |  |  |  |
| [ ]  NIMENRIX [ ]  MENVEO  |  |  |  |  |  |  |
| **Varicella (chickenpox)** |  | [ ]  Right arm[ ]  Left arm | [ ]  SC | [ ]  0.5 mL |  |  |  |
| [ ]  VARILRIX [ ]  VARIVAX III |  |  |  |  |  |  |

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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.** |
| **Meningococcal Quadrivalent (A, C, Y, W-135) Vaccine**  |  | **Varicella (chickenpox) Vaccine** |
| STUDENT’S NAME |  | STUDENT’S NAME |
|  |  |  |
| DOB (YYYY / MM / DD) | MEDICARE # |  | DOB (YYYY / MM / DD) | MEDICARE # |
|  |  |  |  |  |  |  |  |  |
| NAME OF VACCINE:[ ]  **NIMENRIX**[ ]  **MENVEO** | DATE (YYYY / MM / DD) |  | NAME OF VACCINE:[ ]  **VARILRIX**[ ]  **VARIVAX III** | DATE (YYYY / MM / DD) |
|  |  |  |  |  |  |  |
| TIME |  | TIME |
|  |  |  |
| NURSE’S SIGNATURE |  | NURSE’S SIGNATURE |
|  |  |  |

(August 2017)