** 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)