CONSENT FOR GRADE 9 IMMUNIZATIONS

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

PLEASE COMPLETE SECTIONS 1 AND 2

SECTION 1 : STUDENT'S PERSONAL INFORMATION

SCHOOL	GRADE	TEACHER (HOMEROOM)

LAST NAME	FIRST NAME	DATE OF BIRTH (YYYY / MM / DD)

BIRTH GENDER ☐ M ☐ F	MEDICARE #	NAME OF PARENT / LEGAL GUARDIAN

DAYTIME PHONE (work or home) ☐ CELL	OTHER DAYTIME PHONE ☐ CELL	PARENT'S / LEGAL GUARDIAN'S EMAIL

ALERT

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:

HAS YOUR CHILD RECEIVED a COVID-19 VACCINE? ☐ NO ☐ YES*
*IF YES DATE OF COVID VACCINE :

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

☐ YES, vaccinate my child.

☐ NO, do not vaccinate my child.
If no, please specify :_____

Signature of parent/legal guardian ➡	Date (YYYY / MM / DD)

Varicella (chickenpox) Vaccine – 1 dose

☐ YES, vaccinate my child.

☐ NO, do not vaccinate my child.
If no, please specify :_____

Signature of parent/legal guardian ➡	Date (YYYY / MM / DD)

FOR PUBLIC HEALTH NURSE USE ONLY

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) ☐ NIMENRIX ☐ MENVEO ☐ MENJUGATE		☐ Right arm ☐ Left arm	☐ IM	☐ 0.5 mL			
Varicella (chickenpox) ☐ VARILRIX ☐ VARIVAX III		☐ Right arm ☐ Left arm	☐ SC	☐ 0.5 mL			

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

STUDENT'S NAME		
DOB (YYYY / MM / DD)	MEDICARE #	
NAME OF VACCINE: ☐ **NIMENRIX** ☐ **MENVEO** ☐ **MENJUGATE**	DATE (YYYY / MM / DD)	TIME
NURSE'S SIGNATURE		

Varicella (chickenpox) Vaccine

STUDENT'S NAME		
DOB (YYYY / MM / DD)	MEDICARE #	
NAME OF VACCINE: ☐ **VARILRIX** ☐ **VARIVAX III**	DATE (YYYY / MM / DD)	TIME
NURSE'S SIGNATURE		

(July 2021)