

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 <input type="checkbox"/> M <input type="checkbox"/> F	MEDICARE #		NAME OF PARENT / LEGAL GUARDIAN		
DAYTIME PHONE (work or home) <input type="checkbox"/> CELL		OTHER DAYTIME PHONE <input type="checkbox"/> CELL		PARENT'S / LEGAL GUARDIAN'S EMAIL	
A L L E R T	DOES YOUR CHILD HAVE ALLERGIES? <input type="checkbox"/> NO <input type="checkbox"/> YES*				
	*IF YES, TO WHAT AND WHAT TYPE OF REACTION :				
	DOES YOUR CHILD HAVE A HEALTH PROBLEM? <input type="checkbox"/> NO <input type="checkbox"/> YES*				
	*PLEASE EXPLAIN :				
DOES YOUR CHILD TAKE ANY MEDICATIONS? <input type="checkbox"/> NO <input type="checkbox"/> 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:	
<ul style="list-style-type: none"> 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
<input type="checkbox"/> YES, vaccinate my child. <input type="checkbox"/> NO, do not vaccinate my child. If no, please specify : _____	<input type="checkbox"/> YES, vaccinate my child. <input type="checkbox"/> 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) <input type="checkbox"/> NIMENRIX <input type="checkbox"/> MENVEO		<input type="checkbox"/> Right arm <input type="checkbox"/> Left arm	<input type="checkbox"/> IM	<input type="checkbox"/> 0.5 mL			
Varicella (chickenpox) <input type="checkbox"/> VARILRIX <input type="checkbox"/> VARIVAX III		<input type="checkbox"/> Right arm <input type="checkbox"/> Left arm	<input type="checkbox"/> SC	<input type="checkbox"/> 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: <input type="checkbox"/> NIMENRIX <input type="checkbox"/> MENVEO	DATE (YYYY / MM / DD) TIME
NURSE'S SIGNATURE	

Varicella (chickenpox) Vaccine	
STUDENT'S NAME	
DOB (YYYY / MM / DD)	MEDICARE #
NAME OF VACCINE: <input type="checkbox"/> VARILRIX <input type="checkbox"/> VARIVAX III	DATE (YYYY / MM / DD) TIME
NURSE'S SIGNATURE	