

INSTRUCTION SHEET FOR COMPLETING THE

School Immunization Consent Form

- 1 **READ** the information booklet you've been given about the vaccines and the diseases they prevent.
- 2 **TEAR OFF** this Instruction Sheet.
- 3 **COMPLETE** all parts of Sections 1 and 2 on the School Immunization Consent Form.
 - In **Section 1**, be sure to indicate whether the student has any allergies or has had any previous reaction to a vaccine.
 - If the student has ever received any of these vaccines, be sure to note the dates on which they were received in **Section 2**. This will help the nurse to determine which vaccines are needed.
- 4 **SIGN and DATE** the bottom of Section 2.
- 5 **RETURN** the School Immunization Consent Form to the school.

Public Health may get in touch with you if they need more information. After the student has received ALL the vaccines consented to, their online record of immunization will be updated.

SIGN and RETURN the School Immunization Consent Form even if you **DO NOT** want the student to receive any of the vaccines.

WHEN IN DOUBT, ASK!

If you have any questions about immunization, or if there is anything you don't understand, contact your local Public Health office. You'll find contact information in your School Immunization Program booklet or online at www.nshealth.ca/public-health.

Return this consent form to the school. After the student has received ALL the vaccines you consented to, their online record of immunization will be updated. **Please complete in pen if completing the paper form.**

School Immunization Consent Form

This consent form covers the Hepatitis B Vaccine; Human Papillomavirus (HPV 9) Vaccine; Meningococcal Quadrivalent Vaccine; and Tetanus, Diphtheria, and Acellular Pertussis (Tdap) Vaccine. Nova Scotia Health is committed to protecting the privacy of your personal health information, in accordance with the *Personal Health Information Act*. Aggregate immunization data is collected by Public Health and is used for reporting to support planning and management, and to assess coverage rates within Nova Scotia. For more information on the School Immunization Program, and the vaccines offered, see the information booklet found here: nshealth.ca/patient-education-resources/school-immunization-program-information-booklet

Complete Sections 1 and 2.

Section 1: STUDENT’S PERSONAL INFORMATION

Grade: _____

Full Name: _____ Preferred Name: _____

Address: _____ Postal Code:

Parent/Guardian

Other Parent/Guardian

Name: _____ Name: _____

Daytime Phone: _____ Daytime Phone: _____

Email: _____ Email: _____

Family Doctor/Nurse Practitioner Name: _____

School Name: _____ Teacher’s Name and Room Number: _____

Health Card Number: -- Date of Birth:

Year

Month

Day

Does the student have any allergies? ☐ No ☐ Yes

If Yes, list allergies: _____

Have they ever had any reaction to a vaccine in the past? ☐ No ☐ Yes

If Yes, explain: _____

Section 2: PARENT/GUARDIAN CONSENT

Note: A mature minor may override parent/guardian consent if deemed capable.

I have read the information I was given on these four vaccines. I understand the benefits, risks, and possible reactions of each vaccine.

The consent given below is valid for the time needed to give all doses of the vaccines unless I cancel my consent in writing.

By completing this form, I confirm that I have legal authority to make health care decisions for the student named in this consent form.

By signing below, I give consent for the following vaccines to be given (check Yes or No for each of the vaccines) and for emergency treatment (e.g., epinephrine) to be provided, if required:

Hepatitis B Vaccine (two doses)

☐ YES, I CONSENT ☐ NO, I DO NOT CONSENT

If the student has already received Twinrix vaccine, give the dates: Dose 1: _____ Dose 2: _____ Dose 3: _____

If the student has already received Hepatitis B vaccine, give the name of vaccine: _____

and the dates: Dose 1: _____ Dose 2: _____ Dose 3: _____

Human Papillomavirus (HPV 9) Vaccine (one dose)

☐ YES, I CONSENT ☐ NO, I DO NOT CONSENT

If the student has already received this vaccine, give the name of vaccine: _____

and the dates: Dose 1: _____ Dose 2: _____ Dose 3: _____

Meningococcal Quadrivalent Vaccine (one dose)

☐ YES, I CONSENT ☐ NO, I DO NOT CONSENT

If the student has already received this vaccine, give the name of vaccine: _____ and the date: _____.

Tetanus, Diphtheria, and Acellular Pertussis (Tdap) Vaccine (one dose)

☐ YES, I CONSENT ☐ NO, I DO NOT CONSENT

If the student has already received this vaccine, give the name of vaccine: _____ and the date: _____.

SIGNATURE REQUIRED

Signature: _____ Print Name: _____ Date: _____

(Parent/Guardian) (Parent/Guardian)

Public Health may get in touch with you if any other information is needed.

TO BE COMPLETED BY THE PUBLIC HEALTH NURSE OR LICENSED PRACTICAL NURSE

Hepatitis B Vaccine

Vaccine Trade Name: _____

1st Dose: _____ Site: Rt arm ☐ Lt arm ☐ Route: IM ☐ Lot # _____

Time:_____ Date:_____ Signature: _____

2nd Dose: _____ Site: Rt arm ☐ Lt arm ☐ Route: IM ☐ Lot # _____

Time:_____ Date:_____ Signature: _____

Human Papillomavirus (HPV 9) Vaccine

Vaccine Trade Name: _____

1 Dose: _____ Site: Rt arm ☐ Lt arm ☐ Route: IM ☐ Lot # _____

Time:_____ Date:_____ Signature: _____

Meningococcal Quadrivalent Vaccine

Vaccine Trade Name: _____

1 Dose: _____ Site: Rt arm ☐ Lt arm ☐ Route: IM ☐ Lot # _____

Time:_____ Date:_____ Signature: _____

Tetanus, Diphtheria, and Acellular Pertussis (Tdap) Vaccine

Vaccine Trade Name: _____

1 Dose: _____ Site: Rt arm ☐ Lt arm ☐ Route: IM ☐ Lot # _____

Time:_____ Date:_____ Signature: _____