

General Consent for Routine Immunizations

PARENTS/GUARDIANS: USE A PEN, PRINT CLEARLY, AND RETURN THIS COMPLETED FORM TO THE SCHOOL.

SECTION 1: STUDENT'S PERSONAL INFORMATION (PARENT/GUARDIAN MUST COMPLETE THIS SECTION)

Last Name	First Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate
Health Card Number	Address/PO Box, Town, Postal Code		School
Parent/Guardian Name (Print)	Cell Phone ()	<input type="checkbox"/> Text only plan?	Day Phone ()
Your Relationship to this Student	Other Phone ()	Email Address	

SECTION 2: STUDENT'S HEALTH CHECKLIST (PARENT/GUARDIAN MUST COMPLETE THIS SECTION)

- Has this student ever had a serious or life-threatening or allergic reaction to a vaccine or a vaccine component?
No Yes **If yes**, describe:
- Does this student have any medical conditions or severe drug allergies?
No Yes **If yes**, describe:
- Has this student received a blood product or an immune globulin in the past year?
No Yes **If yes**, list product name(s) and date(s) given:
- Is this student taking medication (e.g. prednisone), receiving treatment, or has a medical condition that lowers their immunity (e.g. cancer or HIV)? No Yes **If yes**, describe:
- Please check all that apply:** Has this student ever received a vaccine:

<input type="checkbox"/> Outside of Saskatchewan?	<input type="checkbox"/> In a different community other than where they currently live?
<input type="checkbox"/> In a First Nation's community?	<input type="checkbox"/> From a Doctor, Pharmacist, or Nurse Practitioner?
<input type="checkbox"/> In an Emergency department?	<input type="checkbox"/> That has been paid for? <input type="checkbox"/> In a travel clinic?

If **yes**, specify the vaccine(s), date(s) and location(s) of provider(s) if known and attach a copy of the record(s) if available:

SECTION 3: VACCINES THIS STUDENT IS ELIGIBLE TO RECEIVE (NURSE USE ONLY)

- | | |
|--|--|
| <input type="checkbox"/> Diphtheria, Tetanus, Pertussis, Polio, <i>Haemophilus influenzae</i> type b _____ dose(s) | <input type="checkbox"/> Meningococcal Conjugate C _____ dose(s) |
| <input type="checkbox"/> <i>Haemophilus influenzae</i> type b _____ dose(s) | <input type="checkbox"/> Meningococcal Conjugate ACYW-135 _____ dose(s) |
| <input type="checkbox"/> Hepatitis A _____ dose(s) | <input type="checkbox"/> Pneumococcal Conjugate 13 _____ dose(s) |
| <input type="checkbox"/> Hepatitis B _____ dose(s) | <input type="checkbox"/> Pneumococcal Polysaccharide 23 _____ dose(s) |
| <input type="checkbox"/> Human Papillomavirus (9 HPV types) _____ dose(s) | <input type="checkbox"/> Polio _____ dose(s) |
| <input type="checkbox"/> Measles, Mumps, Rubella _____ dose(s) | <input type="checkbox"/> Tetanus, Diphtheria, Pertussis _____ dose(s) |
| <input type="checkbox"/> Measles, Mumps, Rubella, Varicella (chickenpox) _____ dose(s) | <input type="checkbox"/> Tetanus, Diphtheria, Pertussis, Polio _____ dose(s) |
| <input type="checkbox"/> Meningococcal B _____ dose(s) | <input type="checkbox"/> Varicella (chickenpox) _____ dose(s) |
| | <input type="checkbox"/> Other: _____ dose(s) |

SECTION 4: CONSENT FOR IMMUNIZATION (PARENT/GUARDIAN TO COMPLETE)

- I have read the information in the Ministry of Health immunization fact sheet(s) provided to me for the vaccine(s) listed below.
- I have had the opportunity to ask questions that were answered to my satisfaction.
- I understand the benefits and possible reactions for the vaccine(s), and the potential risks if my child is not immunized.
- I understand that in the rare occurrence of anaphylaxis, emergency treatment will be provided to my child.
- I understand that when a vaccine series requires more than one dose, my consent continues until all required doses of the vaccine have been provided to my child, unless I provide prior written or verbal revocation to the school Public Health Nurse.

As a parent/guardian of this child, I understand and acknowledge that it is my responsibility to:

- Seek medical attention should my child have an unusual or severe reaction following immunization. If this occurs, I will seek treatment for my child and notify public health immediately.
- Inform the school Public Health Nurse of any changes to my child's health status set out in Section 2 which arise after signing this consent form.
- NOTE: It is recommended that parents/guardians discuss consent for immunization with their children. Efforts are first made to get parental/guardian consent for immunizations. However, children at least 13 years of age and older who are able to understand the benefits and possible reactions for each vaccine and the risks of not getting immunized, can legally consent to receive or refuse immunizations in Saskatchewan by providing mature minor informed consent to a healthcare provider.

A PARENT/GUARDIAN MUST CHECK ONLY 1 BOX BELOW AND THEN SIGN AND DATE

- YES I CONSENT FOR MY CHILD TO BE IMMUNIZED WITH ALL OF THE RECOMMENDED VACCINES ABOVE.
- YES I CONSENT FOR MY CHILD TO BE IMMUNIZED WITH THE RECOMMENDED VACCINES EXCEPT FOR _____.
- No I DO NOT CONSENT FOR MY CHILD TO BE IMMUNIZED WITH ANY OF THE RECOMMENDED VACCINES (REFUSAL).

SIGNATURE:

DATE:

