

# 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)

Student's Last Name (print)	Student's First Name (print)	Student's Gender M F Other: _____	Birthdate YY/MM/DD
Health Card Number	Address/PO Box, Town, Postal Code		School
Parent/Guardian Name (print)	Cell Phone ( )	May we text you? Yes No	Preferred Phone Number ( )
Your Relationship to this Student (e.g., mother)		Parent/Guardian 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 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:** \_\_\_\_\_
- Has this student **ever** received vaccines:  Outside of Saskatchewan?  In an Emergency department?  
 That were paid for?  In a travel clinic?  From a Doctor, Pharmacist, or Nurse Practitioner?  
 In a different First Nations community other than where they currently live (if applicable)?  
**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 influenza</i> type b __ dose(s) | <input type="checkbox"/> Meningococcal Conjugate ACYW-135 __ dose(s)      |
| <input type="checkbox"/> <i>Haemophilus influenza</i> type b ____ dose(s)                                      | <input type="checkbox"/> Pneumococcal Conjugate 13 __ dose(s)             |
| <input type="checkbox"/> Hepatitis A __ dose(s)  | <input type="checkbox"/> Pneumococcal Polysaccharide 23 __ dose(s)        |
| <input type="checkbox"/> Hepatitis B __ dose(s)  | <input type="checkbox"/> Polio __ dose(s)                                 |
| <input type="checkbox"/> Human Papillomavirus (9 HPV types) __ dose(s)   | <input type="checkbox"/> Tetanus, Diphtheria, Pertussis __ dose(s)        |
| <input type="checkbox"/> Measles, Mumps, Rubella __ dose(s)  | <input type="checkbox"/> Tetanus, Diphtheria, Pertussis, Polio __ dose(s) |
| <input type="checkbox"/> Measles, Mumps, Rubella, Varicella (chickenpox) __ dose(s)                            | <input type="checkbox"/> Varicella (chickenpox) __ dose(s)                |
| <input type="checkbox"/> Meningococcal B ____ dose(s)  | <input type="checkbox"/> Other: _____ dose(s)                             |
| <input type="checkbox"/> Meningococcal Conjugate C __ 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) checked off above.
- I have had the opportunity to ask questions and they were answered to my satisfaction.
- I understand the benefits and possible reactions (side effects) for the vaccine(s).
- I understand the potential disease risks to my child if they do not get 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 given consent continues until all required doses of the vaccine have been provided to my child, unless I let the school Public Health Nurse know that I cancel my consent.

**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 nurse of any changes to my child's health status set out in Section 2 that 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 \_\_\_\_\_ YY/MM/DD

**Parents - Complete sections 1, 2 and 4 on this for and return it to the school.**

**SECTION 5: NURSE USE ONLY**

Student's Name: \_\_\_\_\_ DOB YY/MM/DD HCN# \_\_\_\_\_

Date consent directives entered into Panorama: \_\_\_\_\_ Nurse initials: \_\_\_\_\_

Use this section if Point of Service documentation is unavailable.

Date given <small>YY/MM/DD</small>	Vaccine	Dose #	Lot #	Dosage	Route	Site	Nurse signature	POS/ Entered
						LA RA		
						LA RA		
						LA RA		
						LA RA		
						LA RA		
						LA RA		
						LA RA		
						LA RA		
						LA RA		
						LA RA		
						LA RA		
						LA RA		
						LA RA		
						LA RA		
						LA RA		
						LA RA		
						LA RA		
						LA RA		
						LA RA		

<b>Verbal consent obtained</b> <input type="checkbox"/>				<b>Mature minor consent obtained</b> <input type="checkbox"/>				<b>Notes:</b>											
Parent/Guardian name				Student signature															
Phone number				Date & Time															
Date & Time				Nurse signature															
Nurse signature																			
	DTaP-IPV-Hib	Hib	HA	HB	HPV-9	MMR	MMRV	MenB	Men-C-C	Men-C-ACYW-135	Pneu-C-13	Pneu-P-23	IPV	Tdap	Tdap-IPV	Var	Other	Other	
<b>Granted</b>																			
<b>Refused</b>																			