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)	Male Female	Birthdate
Health Card Number	Address/PO Box, Town, Postal Code		School
Parent/Guardian Name (print)	Cell Phone ( ) Text only plan? Yes ☐	Preferred Phone Number ( )	Grade / Teacher
Your Relationship to this Student	Parent/Guardian Email Address		

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

1) 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: _____

2) Does this student have any medical conditions or severe drug allergies?
No ❑ Yes ❑ **If yes**, describe: _____

3) 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: _____

4) 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: _____

5) Please check all that apply: Has this student ever received a vaccine:
❑Outside of Saskatchewan? ❑ In an Emergency department? ❑ From a Doctor, Pharmacist, or Nurse Practitioner? ❑That has been paid for? ❑ In a travel clinic? ❑ 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)

- ❑ Diphtheria, Tetanus, Pertussis, Polio, *Haemophilus influenza* type b _____ dose(s)
- ❑ *Haemophilus influenza* type b _____ dose(s)
- ❑ Hepatitis A ___ dose(s)
- ❑ Hepatitis B ___ dose(s)
- ❑ Human Papillomavirus (9 HPV types) ___ dose(s)
- ❑ Measles, Mumps, Rubella ___ dose(s)
- ❑ Measles, Mumps, Rubella, Varicella (chickenpox) ___ dose(s)
- ❑ Meningococcal B ____ dose(s)
- ❑ Meningococcal Conjugate C ___ dose(s)
- ❑ Meningococcal Conjugate ACYW-135 ___ dose(s)
- ❑ Pneumococcal Conjugate 13 ___ dose(s)
- ❑ Pneumococcal Polysaccharide 23 ___ dose(s)
- ❑ Polio ___ dose(s)
- ❑ Tetanus, Diphtheria, Pertussis ___ dose(s)
- ❑ Tetanus, Diphtheria, Pertussis, Polio ___ dose(s)
- ❑ Varicella (chickenpox) ___ dose(s)
- ❑ 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 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 DO CONSENT FOR MY CHILD TO BE IMMUNIZED WITH ALL OF THE RECOMMENDED VACCINES ABOVE.**

❑ YES I DO 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: _____ M F DOB _____ HCN# _____

Date consent directives entered into Panorama:_____ Nurse initials: _____

Use this section if Point of Service documentation is unavailable.

Date given	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		

Verbal consent obtained ❑	Mature minor consent obtained ❑	Notes:
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
Granted																		
Refused																		