SCHOOL VACCINATION CONSENT FORM

See reverse side for instructions on how to complete this form

Step 1: Your Child's Information

Child's Last Name			Child's First Name	Health Card Number
Birthday Year	Month	Day	School	Grade/Class/Teacher
Parent/Legal Guardian Name			Parent/Legal Guardian Daytime Phone	Parent/Legal Guardian Alternative Phone

Step 2: Your Child's Health History

*Note: children with certain medical conditions or a cochlear implant may be eligible for additional doses.

		If selecting **YES**, please explain:
Has your child ever had a reaction to a vaccine?	○ **YES** ○ **NO**	
Does your child have any allergies?	○ **YES** ○ **NO**	
Has your child ever fainted after vaccination?	○ **YES** ○ **NO**	
Does your child have a serious medical condition?*	○ **YES** ○ **NO**	
Does your child take any medication(s) or have a medical condition that weakens the immune system?*	○ **YES** ○ **NO**	
Does your child have a cochlear implant?*	○ **YES** ○ **NO**	

Step 3: Please indicate if your child has received any of the following immunizations, then proceed to step 4.

Meningococcal ACYW-135 (Menactra®, Nimenrix®, Menveo™) received on:	**Hepatitis B** (Twinrix®, Engerix®, Recombivax®) received on:	**Human Papillomavirus (HPV)** (Gardasil®) received on:
Dose 1: _____ (YYYY/MM/DD)	Dose 1: _____ (YYYY/MM/DD)	Dose 1: _____ (YYYY/MM/DD)
Note: The Meningococcal ACYW-135 vaccine is different from the Meningitis C vaccine that your child may have received as a baby.	Dose 2: _____ (YYYY/MM/DD)	Dose 2: _____ (YYYY/MM/DD)
	Dose 3: _____ (YYYY/MM/DD)	

Step 4: Permission for Vaccination. Please check (✓) **YES** or **NO** for each vaccine.

*Note: the second dose of Hepatitis B and HPV is recommended to be given at least 6 months after the first dose, however a longer than recommended interval between doses will provide the same immunity.

Meningococcal ACYW-135 – 1 DOSE *(required for school attendance)* I authorize Halton Region Public Health to administer any doses for which my child is eligible.	◯ **YES**	◯ **NO**
Hepatitis B – 2 DOSES I authorize Halton Region Public Health to administer any doses for which my child is eligible.	◯ **YES**	◯ **NO**
Human Papillomavirus (HPV) – 2 DOSES I authorize Halton Region Public Health to administer any doses for which my child is eligible.	◯ **YES**	◯ **NO**

The consent is valid for the time period needed to give a complete series of the vaccine(s). I acknowledge that I have read the attached fact sheet and understand the expected benefits and possible side effects of the vaccine(s). I have had the opportunity to have my questions answered. I understand that I may withdraw my consent at any time.

Step 5: Parent/Legal Guardian Signature

SIGN HERE _____ **Parent/Legal Guardian Signature** _____ **Date**

Personal health information is collected to obtain consent to administer vaccine(s) listed on this form. Nurses will use this information to make sure it is safe to give the vaccine(s). We may share vaccine records with your child's health care provider unless you ask us not to. You can refuse to provide information on this form, but nurses may not be able to administer vaccines without all information. If you have questions, call 311 to speak to a nurse in the Immunization Services Program.

SCHOOL VACCINATION CONSENT FORM

Instructions on how to complete the School Vaccination Consent Form

Step 1: Please complete all boxes with the most current information.

Step 2: Please check YES **or** NO for each question. If selecting YES, please provide an explanation.

Step 3: If your child received any of the following immunizations, please provide the dates. You can contact your health care provider or check your child's immunization record. **NOTE:** Nurses will only administer vaccines that your child is eligible for and for which consent is provided.

Step 4: For each vaccine, please **only** check YES **or** NO.

Step 5: Consent must be validated with a parent or legal guardian signature.

Step 1: Your Child's Information

Child's Last Name	Child's First Name	Health Card Number
Doe	Jane	123-456-7891-AB
Birthday 2013 (Year) 03 (Month) 19 (Day)	School: St. Mary	Grade/Class/Teacher: 7-2/Mrs. Smith
Parent/Legal Guardian Name: Mary Doe	Parent/Legal Guardian Daytime Phone: 905-123-4567	Parent/Legal Guardian Alternative Phone: 289-456-0321

Step 2: Your Child's Health History — If selecting **YES**, please explain:
*Note: children with certain medical conditions or a cochlear implant may be eligible for additional doses.

Has your child ever had a reaction to a vaccine?	○ YES √ NO	
Does your child have any allergies?	○ YES √ NO	
Has your child ever fainted after vaccination?	○ YES √ NO	
Does your child have a serious medical condition?*	○ YES √ NO	
Does your child take any medication(s) or have a medical condition that weakens the immune system?*	√ YES ○ NO	Remicade
Does your child have a cochlear implant?*	√ YES ○ NO	

Step 3: Please indicate if your child has received any of the following immunizations, then proceed to step 4.

Meningococcal ACYW-135 (Menactra®, Nimenrix®, Menveo™) received on:	**Hepatitis B** (Twinrix®, Engerix®, Recombivax®) received on:	**Human Papillomavirus (HPV)** (Gardasil®) received on:
Dose 1: _____ (YYYY/MM/DD)	Dose 1: 2013/03/25 (YYYY/MM/DD)	Dose 1: _____ (YYYY/MM/DD)
Note: The Meningococcal ACYW-135 vaccine is different from the Meningitis C vaccine that your child may have received as a baby.	Dose 2: 2013/04/30 (YYYY/MM/DD)	Dose 2: _____ (YYYY/MM/DD)
	Dose 3: 2013/08/09 (YYYY/MM/DD)	

Step 4: Permission for Vaccination. Please check (✓) YES or NO for each vaccine.
*Note: the second dose of Hepatitis B and HPV is recommended to be given at least 6 months after the first dose, however a longer than recommended interval between doses will provide the same immunity.

Meningococcal ACYW-135 – 1 DOSE *(required for school attendance)* I authorize Halton Region Public Health to administer any doses for which my child is eligible.	✓ YES	○ NO
Hepatitis B – 2 DOSES I authorize Halton Region Public Health to administer any doses for which my child is eligible.	○ YES	✓ NO
Human Papillomavirus (HPV) – 2 DOSES I authorize Halton Region Public Health to administer any doses for which my child is eligible.	✓ YES	○ NO

The consent is valid for the time period needed to give a complete series of the vaccine(s). I acknowledge that I have read the attached fact sheet and understand the expected benefits and possible side effects of the vaccine(s). I have had the opportunity to have my questions answered. I understand that I may withdraw my consent at any time.

Step 5: Parent/Legal Guardian Signature

SIGN HERE — Mary Doe — Parent/Legal Guardian Signature — 2025/09/12 — Date

To view or submit your child's immunization record, please go to **halton.ca/immunize**. If their record requires updates, please call 311.

Additional Notes:

- If you need to make a **correction** on the consent form, please initial beside the correction made.
- On the school clinic day, public health nurses will review your child's **immunization record** to determine if your child is eligible to receive the vaccines you consented for.
- If your child is **absent** on the school clinic day, please follow up by calling 311 to discuss next steps.
- Students can receive missed or additional doses of the vaccines through their primary care provider, at a public health community immunization clinic, or at a school clinic when the student is in Grade 8.

Personal health information is collected to obtain consent to administer vaccine(s) listed on this form. Nurses will use this information to make sure it is safe to give the vaccine(s). We may share vaccine records with your child's health care provider unless you ask us not to. You can refuse to provide information on this form, but nurses may not be able to administer vaccines without all information. If you have questions, call 311 to speak to a nurse in the Immunization Services Program.