CONSENT FOR GRADE 7 IMMUNIZATIONS

TETANUS, DIPHTHERIA AND PERTUSIS (Tdap) VACCINE
HUMAN PAPILLOMAVIRUS (HPV) VACCINE

PLEASE COMPLETE SECTIONS 1 AND 2

SECTION 1 : STUDENT'S PERSONAL INFORMATION

SCHOOL	GRADE	TEACHER (HOMEROOM)

LAST NAME	FIRST NAME	PREFERRED NAME	DATE OF BIRTH (YYYY / MM / DD)

BIRTH GENDER ☐ M ☐ F	MEDICARE #	NAME OF PARENT / LEGAL GUARDIAN

DAYTIME PHONE (work or home) ☐ CELL	OTHER DAYTIME PHONE ☐ CELL	PARENT'S / LEGAL GUARDIAN'S EMAIL

ALERT

DOES YOUR CHILD HAVE ALLERGIES? ☐ NO ☐ YES*
*IF YES, TO WHAT AND WHAT TYPE OF REACTION :

DOES YOUR CHILD HAVE A HEALTH PROBLEM? ☐ NO ☐ YES*
*PLEASE EXPLAIN :

DOES YOUR CHILD TAKE ANY MEDICATIONS? ☐ NO ☐ YES*
*PLEASE LIST :

SECTION 2 : PARENT / GUARDIAN CONSENT

For the two vaccines, check YES or NO, sign and date.

Your signature will confirm the following :

- I have read the information I was given on the Human Papillomavirus (HPV) and the Tetanus, Diphtheria and Pertussis (Tdap) vaccines.
- I understand the benefits and possible reaction(s) for each vaccine and the risk of not getting immunized.

If you have any questions, please call your local Public Health office.

Tetanus, Diphtheria & Pertussis (Tdap) Vaccine – 1 dose

☐ YES, vaccinate my child.
☐ NO, do not vaccinate my child.
If no, please specify :_____

Has your child received a dose of Tetanus, Diphtheria and Pertussis Vaccine since January 2023? **Date (YYYY / MM / DD)**
☐ NO ☐ YES If yes, give the date :

Signature of parent/legal guardian ➡ | **Date (YYYY / MM / DD)**

Human Papillomavirus (HPV) Vaccine – 2 doses

☐ YES, vaccinate my child.
☐ NO, do not vaccinate my child.
If no, please specify :_____

Signature of parent/legal guardian ➡ | **Date (YYYY / MM / DD)**

FOR PUBLIC HEALTH NURSE USE ONLY

SECTION 3 : TO BE COMPLETED BY PUBLIC HEALTH NURSE

	Lot #	Site	Route	Dosage	Date (YYYY/MM/DD)	Time	Signature
Tdap ☐ ADACEL ☐ BOOSTRIX		☐ Right arm ☐ Left arm	☐ IM	☐ 0.5 mL			
HPV ☐ GARDASIL 9 **DOSE 1**		☐ Right arm ☐ Left arm	☐ IM	☐ 0.5 mL			
HPV ☐ GARDASIL 9 **DOSE 2**		☐ Right arm ☐ Left arm	☐ IM	☐ 0.5 mL			

SECTION 4 : PERSONNAL IMMUNIZATION RECORD

This section is to be completed by the Public Health nurse. **These immunization records will be given to your child after their immunization. Please keep these records with your child's personal health files.**

Tetanus, Diphtheria and Acellular Pertussis (Tdap) Vaccine

STUDENT'S NAME
DOB (YYYY / MM / DD)
MEDICARE #
NAME OF VACCINE : ☐ **ADACEL** ☐ **BOOSTRIX**
DATE (YYYY / MM / DD)
TIME
NURSE'S SIGNATURE

Human Papillomavirus (HPV) Vaccine – DOSE 1

STUDENT'S NAME
DOB (YYYY / MM / DD)
MEDICARE #
NAME OF VACCINE : ☐ **GARDASIL 9**
DATE (YYYY / MM / DD)
TIME
NURSE'S SIGNATURE

Human Papillomavirus (HPV) Vaccine – DOSE 2

STUDENT'S NAME
DOB (YYYY / MM / DD)
MEDICARE #
NAME OF VACCINE : ☐ **GARDASIL 9**
DATE (YYYY / MM / DD)
TIME
NURSE'S SIGNATURE