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 2024? **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 : PERSONAL 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

The personal health information provided here is collected and used by New Brunswick Public Health within the Public Health Information System (PHIS) for the purposes of delivering immunizations, and to prevent, investigate and manage outbreaks of vaccine-preventable disease. Your personal health information is processed in accordance with the ***Personal Health Information Privacy and Access Act***. (July 2024)