Consent for Routine Grade 6 Immunizations

HEPATITIS B (HB) AND HUMAN PAPILLOMAVIRUS (HPV) ARE VACCINE-PREVENTABLE DISEASES.

PARENTS/GUARDIANS: Use a pen, print clearly, complete sections 1, 2 AND 4, and return this form to the school, even if you checked "NO" to a vaccine(s) in section 4.

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 ☐ X ☐ Other: ____	Birthdate YY/MM/DD
Health Card Number	Address/PO Box, Town, Postal Code	School	
Parent/Guardian Name (print)	Phone/Cell Number ☐ Yes ☐ No May we text you?	Teacher	
Your Relationship to this Student (e.g., mother)	Parent/Guardian Email Address ☐ Yes ☐ No May we email you?		

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

1) Does this student have any serious allergies or ever had a serious allergic reaction to a vaccine or vaccine component?
☐ No ☐ Yes **If yes**, describe: _____

2) Does this student have any medical conditions or take medications?
☐ No ☐ Yes **If yes,** describe: _____

3) Has this student received a vaccine that is not showing in their MySaskHealthRecord account (if active), including from a pharmacist, physician, nurse practitioner, travel clinic, First Nations community, emergency department **or** outside of Saskatchewan?
☐ No ☐ Yes **If yes**, send a copy of the immunization record with this consent form for the public health nurse to review. **If you don't have a copy of the immunization record, contact the public health office for assistance.**

SECTION 3: CONSENT FOR IMMUNIZATION (PARENT/GUARDIAN MUST READ THIS SECTION)

- 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, and they were answered to my satisfaction.
- I understand the benefits and possible reactions 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 consent continues until all required doses of the vaccine have been provided to my child, even into the next Grade(s), unless I let the public health nurse know that I revoke 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 the public health nurse immediately.
- Inform the public health nurse of any changes to my child's health status set out in Section 2 that arise after signing this consent form.

SECTION 4: PARENT/GUARDIAN MUST CHECK YES OR NO, AND THEN SIGN AND DATE THIS SECTION.

I GIVE MY CONSENT FOR THIS STUDENT TO BE IMMUNIZED WITH:

☐ **YES** ☐ **NO** **HEPATITIS B SERIES** (2 DOSES FOR MOST STUDENTS)

☐ **YES** ☐ **NO** **HUMAN PAPILLOMAVIRUS SERIES** (2 DOSES FOR MOST STUDENTS)

SIGNATURE _____ **DATE** _____

SECTION 5: NURSE USE ONLY

Student's Name: _____ **DOB** YY/MM/DD _____ **HCN#** _____

Date consent directives entered into Panorama: YY/MM/DD _____ **Nurse initials:** _____

Use this section **ONLY** if Point of Service documentation is unavailable.

Date given	Vaccine	Dose #	Lot #	Dosage	Route	Site LA/RA	Nurse signature	POS/ Entered
YY/MM/DD	HB			1.0 mL	IM			
YY/MM/DD	HB			1.0 mL	IM			
YY/MM/DD	HPV-9			0.5 mL	IM			
YY/MM/DD	HPV-9			0.5 mL	IM			

☐ Verbal consent obtained from parent or guardian

Parent/guardian name:

Phone number:

Date & Time: YY/MM/DD

Nurse signature:

Notes: