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Administrative Use Only						
Reviewer:	Reviewer:					
Date:	Date:					

School	Immunization	Consent Form	(Grada 6 or	Grada 8	/۵۱
SCHOOL	immunization	Consent Form	Grade o or	Grade o	17)

IMPORTANT: Please return this form completed and School: City/Town	= -				
A. Client Information - please print					
Last Name(s):	First Name(s):		Preferred Name(s):		
Address:	City/Town:		Postal Code:		
Date of Birth (yyyy/mm/dd): / /	Age:	Pronoun (s) e.g. she, h	e, they, etc.:		
Manitoba Health Number (6 digits):	Personal Hea	lth Information Number (9 digits):		
 Does your child have any allergies? If yes, please describe: Has your child ever had a serious reaction or cond If yes, please describe: Does your child have any health conditions that re If yes, please describe: 	equire regular visits to a d			Yes Yes Yes	No No No
 Does your child have any conditions that can supp (i.e., HIV, problems with spleen, organ transplant, of If yes, please describe: Is your child taking any medications and/or has re (i.e., steroids, chemotherapy, radiotherapy, immuno If yes, please list: 	etc.)? ecently received or is rece e globulin therapy etc.)?		ent	Yes	No No

Public Health will review your child's vaccination history and vaccinate only if your child requires it.

GRADE 6

YES - I consent to the following vaccine(s):

Check ✓ each of the vaccines you consent to the above-named child receiving.

HBV (Hepatitis B)

HPV (Human Papillomavirus)

Men-C-ACYW

(Meningococcal Conjugate ACYW)

NO - I DO NOT consent to the following vaccine(s):

Check ✓ each of the vaccines you DO NOT consent to the above-named child receiving.

HBV (Hepatitis B)

HPV (Human Papillomavirus

Men-C-ACYW

(Meningococcal Conjugate ACYW)

GRADE 8/9

YES - I consent to the following vaccine(s):

Check ✓ each of the vaccines you consent to the above-named child receiving Tdap (Tetanus, Diphtheria, Pertussis) OR Tdap-IPV (Tetanus, Diphtheria, Pertussis, Polio)

NO - I DO NOT consent to the following vaccine(s):

Check ✓ each of the vaccines you DO NOT consent to the above-named child receiving.

Tdap (Tetanus, Diphtheria, Pertussis) OR Tdap-IPV (Tetanus, Diphtheria, Pertussis, Polio)

Complete ONLY ONE of the following two options

1. Signature of parent/guardian/legal or appointed decision maker	2. Signature of client (mature minor)				
Name:	Name:				
Signature:	Signature:				
Date: Relationship:	Date: Phone Number:				
year/month/day	year/month/day				
Phone number(s): home/cell:w:	Email:				
Email:					

Fact sheets regarding the benefits and risks of the vaccine(s) are available at: www.manitoba.ca/health/publichealth/cdc/div/vaccines.html If you would like to receive a fact sheet or if you have any questions, call your local public health office at:

I have read and understood the fact sheet(s) regarding the risks and benefits of the vaccine(s) that I am consenting to, including potential common side effects of this vaccine. Some vaccines require more than one dose within the year, my consent applies to all doses of the vaccine(s) necessary to complete the series up to one year, unless I withdraw my consent by contacting my local public health office at: www.manitoba.ca/health/publichealth/offices.html. I have had the opportunity to ask questions about the vaccine(s) which were answered to my satisfaction.

Nieus of Book							DI IINI #		
Name of client:							PHIN #: _		
involve the child in guardian/legal or zation(s) if the per to the immunization	n the decision the decision appointed decision administration (s), including the content of the decision (s), including the content of the	pointed decision makers shou on to provide consent to the in decision maker, a child is entitled stering the vaccine determine ing risks and benefits of the vertical ending the informed Consent Guideline	nmuniz led to l s that t accine	zation(s). Alth pe informed a the child unde (s), possible i	ough a obout importants of the contractions of	child may munization the cons to the va	be immun n(s). A chi equences accine, and	ized with the consent of a ld may provide consent to of making a decision with d the risks associated with	a parent/ o immuni- o respect h not being
Information Act and Information about th immunization regist Health Information A information, please i	s. 36(1)(b) of a ne immunization ry can be used Act protects your refer to www.	n is authorized to collect the person the Freedom of Information and Pons you or your child(ren) received to produce immunization record our information. You can have you manitoba.ca/health/publicheal health/publichealth/offices.htm	Protection will be the day or not the day or not the day or not the day of t	on of Privacy Ac recorded in th otify you or you onal health info	t because e provinc r doctor i rmation h	e it is colle ial immuni f a particu idden fron	cted for the zation regis lar immuniz n view from	purpose of administering im try. Information collected in tation has been missed. The latenth health care providers. For m	munizations the provincia Personal ore
ing questions will recognize that this ethnic community African Blac North America	oublic health help assess s list of racia that best do k Chineso n Indigenou	has been collecting informat vaccine coverage and detern I or ethnic identifiers may not escribes your child.	nine th exactl n So Other	e need for ind y match how outh Asian r Prefer no	reased you wou Southeat It to answ	vaccine a uld descri ast Asian wer	ccessibility be your ch White	y in different communities	s. We
First Nations		nuit	,	g. oup	, ,				
	TH	IE FOLLOWING SECTION TO	O BE C	OMPLETED	BY THE	IMMUN	ZATION F	PROVIDER	
Verbal Consen	t								
Date:/_ (yyyy/m	/ nm/dd)	Name:		Relationship (parent/guardian/legal or appointed decision maker/client): Health-Care Provider Signature:					
Verbal Consen	t								
Interpreter's N	ame or ID#:			Phone:				Date://(yyyy/mm/dd)	-
Date yyyy/mm/dd	Vaccine Lot #		М	anufacturer	Dose	Route	Site	Immunizer's Signature	Data Entry
Supplementary All entries must be	/ Information	1							
Date yyyy/mm/dd	Signed	Notes:							