Niagara Region PUBLIC HEALTH

# *CONSENT FORM FOR HUMAN PAPILLOMAVIRUS (HPV) VACCINE GARDASIL ®*

**Please Read Parent Student Letter Before Filling Out Information Below**

## Student Information (Please Print)

**Last Name:** ________________________ **First Name:** ________________________

**Ontario Health Card #** ☐☐☐☐ ☐☐☐ ☐☐☐

**Date of Birth: (yy/mm/dd)** ______/______/______ **School Name:** ________________________

**Teacher:** ________________________ **Home Address:** ________________________

**City:** ________________________ **Postal Code:** ________________________

**Home Phone # (    ) ______- ____________** **Daytime Contact Phone # (    ) ______- ____________**

**Doctor:** ________________ **By providing your health care provider's name you are authorizing Niagara Region Public Health to communicate with that health care provider regarding immunization issues.**

## Health History. Please " ✓ " in correct column below.

| Student's Health History Questions | No | Yes | If "yes", briefly describe |
|---|---|---|---|
| Do you have any serious medical conditions? | | | |
| Have you had previous serious reaction(s) to any immunizations? | | | |
| Do you have any known allergies? (foods, drugs, yeast, aluminum or other) | | | |
| Are you currently pregnant or breastfeeding? | | | |
| Are you feeling well today? | | | |
| Have you received any HPV vaccinations (Gardasil® or Cervarix™) in the past? | | | **If yes, provide date(s)/name of vaccine.** |

**Giving Consent for Vaccinations**

I have read or had explained to me the information about the HPV Vaccine and understand the benefits, side effects and risks of the vaccination. Any questions have been answered to my satisfaction. **This consent is valid until completion of all 3 doses of the HPV(Gardasil) vaccine.**

**Provide vaccination Consent or Refusal by placing "x" in the correct box below. Both parent and student are to sign the form. RETURN FORM TO SCHOOL.**

| Consent for Vaccination | Place "X" | | Refusal | Place "X" |
|---|---|---|---|---|
| I want to receive the HPV (Gardasil®) Vaccine | | | I DO NOT want the HPV (Gardasil®) vaccine | |

Parent/Legal Guardian Signature: ✕________________________

Student Signature: ✕________________________Date: ______________

The personal and/or personal health information collected by NRPH staff is pursuant to the Health Protection and Promotion Act, 1990 (HPPA), The Municipal Freedom of information Act, 1989 (MFIPPA), the Personal Health Information Protection Act, 2004 (PHIPA) and will be used for the purpose of meeting client-identified needs and providing service. Questions about this collection should be directed to: Freedom of Information and Privacy Co-ordinator, 2201 St. David's Road, P.O. Box 1042, Thorold, Ontario, L2V 4T7. Telephone (905)685-1571

## FOR NURSE'S USE ONLY:

| Dose #1 | | Dose #2 | |
|---|---|---|---|
| Vaccine Manufacturer: Merck Frosst | | Vaccine Manufacturer: Merck Frosst | |
| Vaccine Name: Gardasil ™ as per Medical Directive V-50.24 | | Vaccine Name: Gardasil ™ as per Medical Directive V-50.24 | |
| Site: Left Deltoid | | Site: Left Deltoid | |
| Dosage: 0.5 ml | Route: IM | Dosage: 0.5 ml | Route: IM |
| Lot # | Expiry: | Lot # | Expiry: |
| Date: | Time: | Date: | Time: |
| Nurses Signature: | | Health History Reviewed Round #2 ❑<br>Nurses Signature: | |
| Nurses Comments: | | Nurses Comments: | |

| Dose #3 | | | |
|---|---|---|---|
| Vaccine Manufacturer: Merck Frosst | | Vaccine Name: Gardasil ™ as per Medical Directive V-50.24 | |
| Site: Left Deltoid | Dosage: 0.5 ml | | Route: IM |
| | | | |
| Lot # | Expiry: | Date: | Time: |
| Health History Reviewed Round #3 ❑<br>Nurses Signature: | | | |
| Nurses Comments: | | | |

| Additional Notes |
|---|
| Student Absent: |
| Option Sheet Mailed: Date(s) |
| Telephone Calls Made: |
| |
| |
| Plan of Action: |