Halton REGION Hepatitis B Vaccine Consent Form

INSTRUCTIONS FOR PARENTS

1. Read the attached information about the hepatitis B vaccine.
2. Remove the consent form. Complete the front of this page.
3. Return the completed form to your child's teacher by September 14, 2015.
   *Please do **not** sign form if you do not want your child to receive this vaccine.*

Student information

LAST NAME _____ FIRST NAME _____

BIRTHDAY DAY / MONTH / YEAR _____ / _____ / _____ MALE / FEMALE M / F _____ SCHOOL _____ ROOM/GRADE _____

PARENT/GUARDIAN NAME _____ HOME PHONE _____ WORK OR CELL PHONE _____

Student health history

			If yes please explain
Does your child have any allergies?	◯ Yes	◯ No	_____
Has your child ever reacted to a vaccine?	◯ Yes	◯ No	_____
Does your child have a history of fainting or seizures?	◯ Yes	◯ No	_____
Does your child have a serious medical condition?	◯ Yes	◯ No	_____

Consent for immunization

I have read or had explained to me the information about the vaccine. I have had the chance to ask questions, which were answered to my satisfaction. I give consent to having the hepatitis B vaccine administered to me, or to the dependent person named above. This consent applies to all immunization settings operated by the Halton Region Health Department and is valid for the time period needed to give two doses of hepatitis B vaccine, unless consent is withdrawn.

◯ **Yes, please vaccinate my child with 2 doses of the hepatitis B vaccine**

PARENT/GUARDIAN SIGNATURE _____ DATE _____

◯ **No, please do not vaccinate my child with the hepatitis B vaccine**

◯ **No, do not vaccinate. My child already received the hepatitis B vaccine on the following dates:**

Check one: ◯ Twinrix® ◯ Engerix®-B ◯ Recombivax HB®

DOSE 1 DATE **DOSE 2 DATE** **DOSE 3 DATE**

Personal health information on this form is collected pursuant to sections 5 of the *Health Protection and Promotion Act*, R.S.O. 1990, c. H. 7 and will be used for obtaining express consent to treatment and for maintaining a record of immunization. Upon request, this record may be shared with your primary health care provider unless you instruct us not to do so. You are not required to provide your information on this form, although not providing your information will affect your ability to receive immunization. Questions about this collection can be directed to nurses within the Immunization Services Program, Halton Region Health Department, 1151 Bronte Road, Oakville, ON, L6M 3L1. Dial 311 or 905-825-6000 or toll free at 1-866-442-5866

Nurse's Assessment

Child's name: _____

Screening questions to be answered on day of clinic (to be completed by Health Department nurse):

	DOSE 1	DOSE 2	NOTES
Are you feeling well today?	○ Yes ○ No	○ Yes ○ No	_____
Has anything changed with your health recently?	○ Yes ○ No	○ Yes ○ No	_____
Do you have a fever or have you started antibiotics in the last 24 hours?	○ Yes ○ No	○ Yes ○ No	_____
Do you have any questions you would like to ask?	○ Yes ○ No	○ Yes ○ No	_____

VACCINE INFORMATION

Entered in Panorama: Dose 1 ○ Dose 2 ○

Dose 1

○ **Engerix® - B 1.0 mL i.m.**
○ **Recombivax HB® 1.0 mL i.m.**

○ **Parent/guardian screening questions reviewed – no change**
○ Initial screening questions reviewed
○ Immunization record assessment completed
○ Given per current vaccine-specific medical directive

DATE	TIME	LOT #	DELTOID SITE	SIGNATURE
			R L	

Dose 2

○ **Engerix® - B 1.0 mL i.m.**
○ **Recombivax HB® 1.0 mL i.m.**

○ **Parent/guardian screening questions reviewed – no change**
○ Initial screening questions reviewed
○ Immunization record assessment completed
○ Given per current vaccine-specific medical directive

DATE	TIME	LOT #	DELTOID SITE	SIGNATURE
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NURSE'S NOTES

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