SCHOOL-BASED VACCINES CONSENT FORM 2025-2026

Hepatitis B (Hep B), Human Papillomavirus (HPV-9), Meningococcal Quadrivalent Conjugate (Men-C-ACYW-135)

Student and/or Parent/Guardian to review and complete steps 1-3

Step 1 – Student Information

Legal Last Name:	Legal First Name:	Gender:
Address:	City:	Postal Code:
Date of Birth (YYYY/MM/DD):	School:	Phone #:
Health Card Number (optional):		Other phone #:

Step 2 – Student Health Questions

Please answer the following:	If yes, please explain	Durham Region Health Department Use Only Date (YYYY/MM/DD), Time, Signature, Designation:
1) Have you ever had a **severe** reaction to any vaccine? 2) Do you have allergies? 3) Do you have an immune system or bleeding disorder?	O No O Yes _____ O No O Yes _____ O No O Yes _____	

Step 3 – Consent for Vaccines

Select the vaccine(s) you would like your child to receive: Yes or No	Immunization History Indicate if your child has already received the vaccine(s)
Hepatitis B O Yes O No	Dose 1: _____ Dose 2: _____ Dose 3 (if applicable): _____
Human Papillomavirus 9 O Yes O No	Dose 1: _____ Dose 2: _____
Meningoccocal C-ACYW-135 O Yes O No ***Required under the Immunization of School Pupils Act**	Dose 1: _____ Note: the Meningococcal ACYW-135 vaccine is different from the Meningitis C vaccine that your child may have received as a baby.

STUDENT & PARENT/GUARDIAN: **Before signing, read "Section A" (back of the form); by signing this form, you acknowledge you understand "Section A".**

STUDENT: signature: _____ Date (YYYY/MM/DD)_____

PARENT/GUARDIAN: signature: _____ Date (YYYY/MM/DD)_____

Print parent/guardian name: _____

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	*Men represents Men-C-ACYW-135			
1) Has anything changed since "**Step 2**" was completed?	O No O Yes	O No O Yes	O No O Yes	O No O Yes
2) Are you feeling sick today?	O No O Yes	O No O Yes	O No O Yes	O No O Yes
3) Do you give consent to receive the vaccine(s) today?	Hep B O No O Yes HPV-9 O No O Yes Men* O No O Yes	Hep B O No O Yes HPV-9 O No O Yes Men* O No O Yes	Hep B O No O Yes HPV-9 O No O Yes Men* O No O Yes	Hep B O No O Yes HPV-9 O No O Yes Men* O No O Yes
4) Vaccines given at a DRHD clinic *Document the vaccine administration in the provincial record	Hep B O HPV-9 O Men* O	Hep B O HPV-9 O Men* O	Hep B O HPV-9 O Men* O	Hep B O HPV-9 O Men* O
5) Completed by: (Date (YYYY/MM/DD), time, signature and designation)				

SECTION A: Statements & Disclosure

*** Men-C-ACYW-135 vaccine:** Is required under the "Immunization of School Pupils Act"; not having it may result in a school suspension. You must contact the Health Department if you object to immunization based on conscience or religious beliefs or if the student/child cannot be immunized for medical reasons.

Student Signature Statement: I have read and/or have had explained to me the information in the Meningococcal Quadrivalent Conjugate vaccine (Men-C-ACYW-135)*, Human Papillomavirus 9 vaccine and Hepatitis B vaccine School Immunization Clinics Facts Sheet, Facts About and/or information on durham.ca/immunize and I understand the information provided. **I know that if I do not cancel my consent, this form will be used for the vaccine series.** I know that my consent is voluntary, and I can call the Durham Region Health Department to cancel my consent.

Parent/guardian Signature Statement: I have read and/or have had explained to me the information in the Meningococcal Quadrivalent Conjugate vaccine (Men-C-ACYW-135)*, Human Papillomavirus 9 vaccine and Hepatitis B vaccine School Immunization Clinics Facts Sheet, Facts About and/or information on durham.ca/immunize and I understand that my child will be offered the vaccine(s) at this clinic.

Personal Health Information Disclosure:

We collect, use and disclose your personal health information under the authority of the Health Protection and Promotion Act R.S.O. 1990 c.H.7, s. 5 and under the Immunization of School Pupils Act, R.S.O. 1990, s. 11(1) and its Regulations. This information is collected for the purpose of assessing, keeping records and reporting on the immunization status of children going to schools in the province of Ontario. Information collected is maintained electronically in a shared provincial immunization information system. Questions about this collection of information should be sent to the Manager, Health Information, Privacy and Security, Durham Region Health Department, at 605 Rossland Rd E., P.O. Box 730, Whitby, ON, L1N 0B2, (905) 668-7711. All client contact will be documented on a client record as required by the Health Department and in accordance with College of Nurses, and/or other Durham Region Health Department policies. All information will be kept private and will not be shared outside the health care team unless required by legislation (e.g. reason to suspect that someone may be harmed). Information may be shared with members of the health care team to help with effective care/service(s). The health care team is made up of staff employed or contracted by Durham Region Health Department to provide service to you. At any point during the time you are receiving service(s), you can ask that we do not share information with members of the health care team.

SECTION B: Durham Region Health Department Use Only

Vaccine Administration (Contingency)

Hep B Vaccine (2 doses, 1mL)

IMMUNIZER TO FILL OUT VACCINE ADMINISTRATION SECTION BELOW:

DOSE 1	Date (YYYY/MM/DD):	Time:	Print name (as per CNO registration):			Initials:	O RN O RPN
	Vaccine Name:		Lot:	Expiration:	Route: O IM	Dose: _____mL	Deltoid Site: O Right O Left
DOSE 2	Date (YYYY/MM/DD):	Time:	Print name (as per CNO registration):			Initials:	O RN O RPN
	Vaccine Name:		Lot:	Expiration:	Route: O IM	Dose: _____mL	Deltoid Site: O Right O Left

HPV-9 Vaccine (2 doses, 0.5mL)

IMMUNIZER TO FILL OUT VACCINE ADMINISTRATION SECTION BELOW:

DOSE 1	Date (YYYY/MM/DD):	Time:	Print name (as per CNO registration):			Initials:	O RN O RPN
	Vaccine Name:		Lot:	Expiration:	Route: O IM	Dose: _____mL	Deltoid Site: O Right O Left
DOSE 2	Date (YYYY/MM/DD):	Time:	Print name (as per CNO registration):			Initials:	O RN O RPN
	Vaccine Name:		Lot:	Expiration:	Route: O IM	Dose: _____mL	Deltoid Site: O Right O Left

Men-C-ACYW-135 (0.5mL)

IMMUNIZER TO FILL OUT VACCINE ADMINISTRATION SECTION BELOW:

Date (YYYY/MM/DD):	Time:	Print name (as per CNO registration):			Initials:	O RN O RPN
Vaccine Name:		Lot:	Expiration:	Route: O IM	Dose: _____mL	Deltoid Site: O Right O Left

Vaccine(s) given as per Durham Region Health Department Vaccination **Medical Directive #49**