Santé
et Services sociaux
Québec

DT9244

User's name			
Health insurance number	Expiry date	Year	Month
Parent's name			
Area code	Phone number	Area code	Phone numer (other)
Address (number, street)			
City		Postal code	

CONSENT FOR VACCINATION AGAINST MEASLES AT SCHOOL

- Fill out all sections of the form including the box above using a pen.
- Sign the form.
- Detach the form from the pamphlet and return it quickly to the school, whether or not you consent to vaccination.

Details of Person to be Vaccinated

(To be completed by a parent or guardian of a child aged under 14, OR by the person if aged 14 or over)

Additional Identification

Name of school:	Class:	Your relationship to the child: ☐ Parent 1 ☐ Parent 2 ☐ Guardian ☐ Person aged 14 or over
Parent 1's name:	Parent 2's name:	
Guardian's name (if applicable):	Area code	Phone number where you can be reached:

Information on the Person's Vaccination History

Person born before 1970

Those born before 1970 are considered to be protected against measles and MUST NOT complete any of the remaining sections of the form.

Person born in or after 1970

Those born since 1970 must check whether they are adequately vaccinated AND provide proof of this[1]. Otherwise, they must complete the remaining sections of this form.

First step, check which of the following situations applies.

1. The person was born between 1970 and 1979, and received a single dose of measles vaccine on or after his or her first birthday AND can provide proof of this[1]:

☐ Yes ☐ No ☐ Don't know or cannot interpret the vaccination record

OR

2. The person was born in or after 1980 and has received two doses of measles vaccine, the first on or after his or her first birthday AND can provide proof of this [1]:

☐ Yes ☐ No ☐ Don't know or cannot interpret the vaccination record

OR

3. The person has already had measles AND can provide proof of this [1]:

☐ Yes ☐ No ☐ Don't know

If you answered YES to any of the above situations, the person is considered protected and:

You must not complete the remaining sections but have to sign this form and MUST attach proof[1].

If you answered NO or DON'T KNOW, the person is considered as being not protected against measles:

You must complete and sign the following sections of the form.

[1] <u>**VALID PROOF OF VACCINATION**</u>

- the person's vaccination record, or a photocopy of it;

  <u>or</u>

- an attestation by a physician or nurse, giving the name of the vaccine and the exact dates (day, month and year) of vaccination;

  <u>or</u>

- an attestation by a physician certifying that the person has had measles, specifying the date or with an attached copy of the laboratory result.

Consent (Decision)

Vaccination is offered to persons considered as not being protected against measles.

If as a parent or guardian of a child aged under 14, you cannot supply proof that the child has been vaccinated or has had the disease, you must decide on whether your child should be vaccinated.

If you are aged 14 or over, you can consent to receive health care yourself, including vaccination.

The explanations provided in this leaflet will enable you to make an informed decision.

After reading the information about the Measles, Mumps and Rubella vaccine (MMR), you can either consent to or refuse vaccination by checking the appropriate box. You must then sign to confirm your consent or refusal.

If you consent to vaccination, you must complete the section *Medical History of the Person to be Vaccinated.*

Consent or Refusal to Vaccination

☐ I CONSENT to vaccination against Measles, Mumps et Rubella.

☐ I REFUSE vaccination against Measles, Mumps and Rubella and I understand that if a case of measles develops in the establishment and that, in order to protect the health of children and those around them, an unvaccinated person will be removed from school until the end of the outbreak.

Signature of parent, guardian or person aged 14 or over ____________________ Date (year/month/day) ____________________

Medical History of the Person to be Vaccinated

(Complete only if you consent to vaccination)

1. Serious allergic reaction following vaccination requiring urgent medical care:

   ☐ Yes ☐ No If yes, specify the vaccine: ____________________

2. History of allergy to an antibiotic called neomycin:

   ☐ Yes ☐ No ☐ Don't know

3. Immune-system problem resulting from a disease (e.g. leukemia) or medication being taken currently (e.g. chemotherapy):

   ☐ Yes ☐ No If yes, give details: ____________________

4. Immunoglobulin injection in the past eleven months:

   ☐ Yes ☐ No

5. Currently pregnant:

   ☐ Yes ☐ No ☐ Don't know ☐ Not applicable

If you answered YES to any of these questions, a nurse will contact you to assess whether the vaccine can be administered to the person to be vaccinated.

CLSC USE ONLY

Reserved for administrative use

User's name:

Record no.:

SI-PMI ID no.:

Vaccination Center Details

CLSC's name: | CLSC's address:

School's name: | Target group: ☐ Students ☐ Others, specify: ____________

For students, check the grade level: ☐ Kindergarten ☐ Primary ☐ Secondary ☐ Other, specify : ____________

Form Validation

Number of doses of vaccine to be administered: ☐ Single dose ☐ Two doses ☐ None

If none: ☐ Adequate proof of vaccination ☐ Disease attestation ☐ Positive diagnostic test ☐ Refusal of vaccination ☐ Contraindication

Nurse's signature: | License no.: | Date: Year | Month | Day

Details of Vaccination

First dose

Contraindication to vaccination (specify):

CLSC's name: | CLSC's address:

Vaccination site:

Vaccine Name	Batch Number	Dose	Injection Site
Priorix		Contents of the single-dose format SC	☐ Left arm ☐ Right arm
Other, specify: ____________		Contents of the single-dose format SC	☐ Left arm ☐ Right arm

Date of vaccination: Year | Month | Day — Time of vaccination: hour | minutes — Notes:

Nurse's signature: | License no.:

If a 2nd person has administered the vaccines, nurse or auxiliary nurse's signature: | License no.:

Second dose (if applicable)

Contraindication to vaccination (specify):

CLSC's name: | CLSC's address:

Vaccination site:

Vaccine Name	Batch Number	Dose	Injection Site
Priorix		Contents of the single-dose format SC	☐ Left arm ☐ Right arm
Other, specify: ____________		Contents of the single-dose format SC	☐ Left arm ☐ Right arm

Date of vaccination: Year | Month | Day — Time of vaccination: hour | minutes — Notes:

Nurse's signature: | License no.:

If a 2nd person has administered the vaccines, nurse or auxiliary nurse's signature: | License no.: