Santé et Services sociaux Québec

DT9244

SCHOOL MEASLES VACCINATION AND PROTECTION STATUS FORM

File No.	
User Name and Surname	
Date of birth	Year / Month / Day — Gender ☐ M ☐ F
Health Insurance No.	Expiration: Year / Month
Address	
City	Postal Code

- Fill in the form in block letters, including the box with a pen.
- Sign and detach the form from the leaflet and return it to your school without delay, whether or not you accept the vaccination.

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

Name of the School:		Group:
Name of Parent 1:	Name of Parent 2:	Name of Guardian (if applicable):
Your Status: ☐ Parent 1 ☐ Parent 2 ☐ Guardian ☐ Person Aged 14 or over		
Area Code Telephone No.		If you agree to be contacted by e-mail, please enter it here:

INFORMATION ON THE PROTECTION OF THE PERSON AND CONSENT (DECISION)

After verification, information on measles protection is not available. Please attach one of the following valid proofs of protection:

- Born before 1970 (no proof required).
- Attestation from a health-care professional showing names and complete vaccination dates (e.g., booklet or photocopy)
  - o 2 doses of vaccine after age 1 are required if born in 1980 or later;
  - o 1 dose of vaccine after the age of 1 is required if the person was born between 1970 and 1979;
- Attestation from a health professional certifying that the person has had measles and specifying the date;
- Laboratory results.

If no proof can be provided, the person can be vaccinated against measles if he or she wishes. Explanations allowing you to make a clear decision are provided in this leaflet. For more information, please contact your school nurse, a health professional, or Info-Santé 811.

Consent or refusal to vaccination against measles, mumps, and rubella, with or without varicella.

☐ **DOES NOT APPLY,** as the person is considered protected against measles (attach proof if required).

☐ **I CONSENT** to vaccination against the following diseases **if required** following analysis by the health professional. You must complete the ***Medical history of the person to be vaccinated*** section below.

- ☐ Measles, mumps, and rubella vaccine
- ☐ Measles, mumps, rubella, and **varicella** vaccine

☐ **I REFUSE** vaccination and I understand that in the event of a case of measles at school, an unvaccinated person would be withdrawn from school until the end of the outbreak to protect him or herself and those around him or her.

Signature of parent, guardian. or person aged 14 or over		**Date**	Year / Month / Day

MEDICAL HISTORY OF THE PERSON TO BE VACCINATED (To be completed only if you consent to vaccination)

1. Severe allergic reaction to a vaccine or other product (e.g. neomycin), requiring emergency medical care:
   ☐ Yes ☐ No If yes, specify: _____
2. Immune system problem due to a disease (e.g. cancer) or a medication currently being taken (e.g. cancer treatment):
   ☐ Yes ☐ No If yes, specify: _____
3. Injection of immunoglobulin, blood, or blood products in the last 11 months: ☐ Yes ☐ No
4. Injection of vaccines 4 weeks prior to vaccination: ☐ Yes ☐ No
5. Had chickenpox after 1 year of age: ☐ Yes ☐ No ☐ Don't know
6. Currently pregnant: ☐ Yes ☐ No ☐ Don't know ☐ Not applicable

If you answered YES to any of these questions, a healthcare professional will contact you.

User name	File No.

ID SI-PMI No.

FOR USE BY THE PROFESSIONAL VACCINATOR

TELEPHONE CONSENT
(Complete this section only if consent is obtained by telephone)

Notes :

Professional Signature ☐ Nurse ☐ Doctor ☐ Respiratory Therapist ☐ Midwife ☐ Pharmacist		Permit No.:	**Date**	Year Month Day
Name of Witness:			**Date**	Year Month Day

VACCINATION 1

Contraindications/precautions to vaccination (please specify):

Vaccination Site: | **Other dose required:** ☐ Yes ☐ No | ☐ **SI-PMI entry**

Date of vaccination (year, month, day)	Time of Vaccination	Name of Vaccine	Batch Number	Dose and Route of Administration	Area of the Injection
		☐ M-M-R II ☐ Proquad ☐ Other: _____		Contents of SC Single-Dose Format	☐ Left Arm ☐ Right Arm

Notes : _____

INFORMATION ON THE PROFESSIONAL AUTHORIZED TO INITIATE AND CARRY OUT THE VACCINATION

☐ Nurse ☐ Doctor ☐ Respiratory Therapist ☐ Midwife ☐ Pharmacist

Name:	Signature:	Permit No.:

INFORMATION ON THE PERSON WHO ADMINISTERED THE VACCINE
(If different from the professional authorized to initiate and carry out the vaccination)

Name:	Signature:	Profession:	Permit No.:

VACCINATION 2 (if applicable)

Contraindications/precautions to vaccination (please specify):

Vaccination Site: | **Other dose required:** ☐ Yes ☐ No | ☐ **SI-PMI entry**

Date of vaccination (year, month, day)	Time of Vaccination	Name of Vaccine	Batch Number	Dose and Route of Administration	Area of the Injection
		☐ M-M-R II ☐ Proquad ☐ Other: _____		Contents of SC Single-Dose Format	☐ Left Arm ☐ Right Arm

Notes : _____

INFORMATION ON THE PROFESSIONAL AUTHORIZED TO INITIATE AND CARRY OUT THE VACCINATION

☐ Nurse ☐ Doctor ☐ Respiratory Therapist ☐ Midwife ☐ Pharmacist

Name:	Signature:	Permit No.:

INFORMATION ON THE PERSON WHO ADMINISTERED THE VACCINE
(If different from the professional authorized to initiate and carry out the vaccination)

Name:	Signature:	Profession:	Permit No.: