Santé et Services sociaux Québec

DT9246

File number	
Child's First and Last Name	
Date of Birth (Year / Month / Day)	Gender ☐ M ☐ F
Health Insurance Number	Expiration (Year / Month)
Address	
City	Postal Code

CONSENT FORM FOR VACCINATION AGAINST HEPATITIS A AND HUMAN PAPILLOMA VIRUS (HPV) IN GRADE 4 OF PRIMARY SCHOOL

- ***Complete all sections of the form, including the box above, using a pen.***
- ***Sign and detach the form from the leaflet and return it to the school, whether or not you accept the vaccination.***

IDENTIFICATION OF THE PERSON

Name of the school :		Group :
Name of parent 1 :	Name of parent 2 :	Guardian's name (if applicable)

Your status: ☐ Parent 1 ☐ Parent 2 ☐ Guardian

Area Code Telephone No.	If you wish to be contacted by e-mail, please enter your e-mail address below:

CHILD'S MEDICAL AND VACCINATION HISTORY

1. Has your child ever had a severe allergic reaction that required emergency medical care? ☐ Yes ☐ No
   If yes, specify the reason: ☐ Vaccine ☐ Other, specify: _____
2. Does your child have problems with his or her immune system because of an illness *(e.g., cancer)* or a medication *(e.g., cancer treatment)*? If so, your child may receive an additional dose ☐ If yes, specify : _____ ☐ No

Please provide your child's vaccination record, whether or not you accept the vaccination. This information will be validated and recorded, including the doses administered.

CONSENT (DECISION) OF PARENT OR GUARDIAN

As the parent or guardian of a child under the age of 14, you are responsible for making decisions about his or her vaccination.

The explanations that will allow 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.

1. Indicate whether you agree or refuse to have your child vaccinated against hepatitis A.

☐ **I AGREE** that my child receive this vaccine following the health professional's analysis.

☐ **I DO NOT WANT** my child to receive this vaccine.

☐ **DOES NOT APPLY** because my child has already been vaccinated against hepatitis A or has already had hepatitis A :

Date of vaccination or illness: _____

2. Indicate whether you agree or refuse to have your child vaccinated against HPV (human papillomavirus).

☐ **I AGREE** that my child receive this vaccine following the health professional's analysis.

☐ **I DO NOT WANT** my child to receive this vaccine.

☐ **DOES NOT APPLY** because my child has already been vaccinated against HPV : Date of vaccination or illness: _____

Signature of parent or guardian		**Date**	Year / Month / Day

User's name	File number

SI-PMI ID no.

FOR USE BY THE PROFESSIONAL VACCINATOR

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

Notes :

Signature of professional ☐ Nurse ☐ Doctor ☐ Respiratory therapist ☐ Midwife ☐ Pharmacist		Permit No:	**Date**	Year Month Day	
Name of Witness:			**Date**	Year Month Day	

DETAILS OF IMMUNIZING PRODUCTS ADMINISTERED

Date of vaccination (year, month, day)	Time of vaccination	Name of immunizing product (vaccine)	Batch No.	Quantity/ unit	Administration route	Administration Site		
					Intramuscular	Left Arm	Right Arm	Initials
		☐ Havrix ☐ Vaqta ☐ Others: _____		0,5 ml	I.M.	☐	☐	
		☐ Gardasil 9 ☐ Others: _____		Unidose content	I.M.	☐	☐	

VACCINATION SITE: ☐ SI-PMI Entry

INFORMATION ON THE AUTHORIZED PROFESSIONAL WHO INITIATED OR CARRIED OUT THE VACCINATION

☐ Nurse ☐ Doctor ☐ Respiratory Therapist ☐ Midwife ☐ Pharmacist

Name:	Initials:	Signature:	Permit No.:

INFORMATION ON THE PERSON WHO ADMINISTERED THE VACCINE(S)
(If different from the authorized professional who initiated or carried out the vaccination)

Name:	Initials:	Signature:	Profession (specify):	Permit No.:
Name:	Initials:	Signature:	Profession (specify):	Permit No.:

Notes :