

Meningococcal (Men ACYW-135) Vaccine Consent Form

Student's Name: (Last) _____ (First) _____

Birth date: (Year) _____ (Month) _____ (Day) _____ Sex: Male Female

Ontario Health Card Number (if available): _____

School Name: _____ Class: _____

Parents:

- a) Please complete either the **YES** or **NO** section.
b) Write down if your child has already received a meningococcal "meningitis" vaccine.

YES, I consent to have Toronto Public Health administer one dose of Meningococcal (Men ACYW-135) vaccine to my child

_____. I have read the Toronto Public Health Meningococcal (Men ACYW-135) fact sheet. I understand the benefits, risks and possible side effects to my child from vaccination with Meningococcal (Men ACYW-135). I understand I can withdraw my consent at any time. If my child has an adverse reaction to the vaccine I will go to a physician immediately and contact Toronto Public Health. Only one dose of this vaccine is required to protect my child at this time.

Date: _____ Signature: _____ Day phone # _____
yyyy/mm/dd (Mother / Father / Legal Guardian)

OR -----

MY CHILD HAS ALREADY RECEIVED THE FOLLOWING Meningococcal meningitis vaccine(s):

Menomune[®] _____ (date vaccine given)

Men AC[®] _____ (date vaccine given)

MENACTRA[®] _____ (date vaccine given)

Menjugate[®]/NeisVac-C[®]/Meningitec[®] _____ (date vaccine given)

OR -----

NO, I do not consent to have Toronto Public Health administer the **Meningococcal (Men ACYW-135)** vaccine to my child _____. I understand the possible consequences if my child is not vaccinated.

Date: _____ Signature: _____

Call the Immunization Information Line at 416-392-1250:

- If your child receives meningococcal vaccine in the future from another health care provider
- If you need more information about this vaccine

Personal health information on this form is collected under the authority of the Health Protection and Promotion Act, R.S.O. 1990, c. H. 7. It is used for the Toronto Public Health Vaccine Preventable Diseases Program. **The confidentiality of this information is protected.** For more information, visit our Privacy Statement at www.toronto.ca/health/information_practice_statement.htm or contact Manager, Vaccine Preventable Diseases - 850 Coxwell, Avenue, Toronto, ON, M4C 5R1 or by telephone: 416 392-1250.

FOR NURSE'S USE ONLY

Meningococcal (Men ACYW-135) vaccine required : yes no

Nursing Assessment Questions

1. Have you received needles for Meningococcal (Men ACYW-135) immunization before today?	<input type="checkbox"/> yes <input type="checkbox"/> no
2. Have you ever had a reaction to any immunization in the past?	<input type="checkbox"/> yes <input type="checkbox"/> no
3. Do you understand what the needle is for?	<input type="checkbox"/> yes <input type="checkbox"/> no
4. Are you allergic to the following: i/ Latex ii/ Diptheria Toxoid iii/ Other	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no _____
5. Have you ever been diagnosed with Guillain-Barre Syndrome (GBS) (note: GBS is a neurological disorder that causes muscle paralysis)	<input type="checkbox"/> yes <input type="checkbox"/> no
6. Are you sick today with anything more than a cold? Do you have a fever?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no
7. Do you have any serious health problems, i.e. seizures, paralysis, history of fainting? Are you taking any medication that may lower your immune system, e.g. anti-cancer agent?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no Comments:
8. Do you think you might be pregnant?	<input type="checkbox"/> yes <input type="checkbox"/> no

<p><u>Nursing Notes:</u></p>	<p><u>Vaccine:</u> MENACTRA® Dose: 0.5 ml Other: _____</p> <p>Lot # _____</p> <p>R / L deltoid Route: <u>IM</u></p> <p>Date: _____ Time: _____</p> <hr/> <p align="center">Signature of Nurse</p>
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