



CONSENT FOR SCHOOL IMMUNIZATIONS GRADE 6

Section 1: Child's personal information		
Last name	First name	Date of birth YYYY/MM/DD
School and class name		Health card #
Name of parent/guardian		Relationship to child
Cell phone	Alternate phone	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> X
Allergies to what: Has your child ever had a serious or life threatening allergic reaction? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Allert : Has your child had previous reaction to immunization? <input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes explain below.		Does your child have any chronic conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes explain below.

Section 2: consent		
For each vaccine listed below, check yes or no, sign and date. It is very important that you complete and return this form.		
I understand the information in the Yukon Immunization Information Sheets for the immunizations listed below. I understand the benefits and possible reactions for each immunization and the risk of not getting immunized. I have had the opportunity to ask questions. I understand this consent is valid for the vaccine(s) listed below unless the consent is cancelled.		
I understand that the community health nurse will review my child's personal immunization record and offer only those immunizations that are required in order to provide complete protection according to the Yukon Immunization Schedule.		
Human Papilloma Virus (HPV)		
I want my child immunized <input type="checkbox"/> Yes <input type="checkbox"/> No	Signature	Date YYYY/MM/DD
Measles-Mumps-Rubella		
I want my child immunized <input type="checkbox"/> Yes <input type="checkbox"/> No	Signature	Date YYYY/MM/DD

COMMUNITY HEALTH USE ONLY		
Telephone consent obtained from:	For: MMR <input type="checkbox"/> Yes <input type="checkbox"/> No HPV <input type="checkbox"/> Yes <input type="checkbox"/> No	Nurse's signature:
Relationship to child:		Date: YYYY/MM/DD