Vancouver CoastalHealth
Promoting wellness. Ensuring care.

BLANK CONSENT FOR SCHOOL IMMUNIZATION (VACCINATION)

TO PARENT/GUARDIAN/REPRESENTATIVE OF:

Address: **PHN:** **PARIS ID:**

DOB: **Age:**

IMPORTANT: COMPLETE AND RETURN THIS FORM TO THE SCHOOL

PART A: VACCINATION HISTORY

Our records show that _____ has had the following vaccines.
If this is not complete or correct, attach a copy of your child's vaccination record.

Description	Dose	Date	Age Given	See Note	Description	Dose	Date	Age Given	See Note

PART A2: CHICKENPOX DISEASE HISTORY

Children who have not had chickenpox **disease** at 12 months of age or older need **2 doses** of chickenpox (Varicella) vaccine.
Has your child had chickenpox disease at 12 months of age or older? ☐ Yes ☐ No

PART B: CONSENT FOR VACCINES STARTING: ____-____

Based on the BC Vaccine Schedule and our records, we recommend that your child be vaccinated for the disease(s) listed below. If you have attached more information, we will review your record and only give vaccines that are still needed.

For each vaccine
✓check Yes or No.
Sign and date below.

If you have any questions, please call the number located on the top of this page.

Vaccine	Description	I want my child immunized
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Information for parents/guardians/representatives about mature minor consent in the secondary school setting (e.g. grade 9): Please make every effort to discuss the information provided for the vaccines listed above with the child, and to involve the child as much as possible in the decision to provide consent to immunization. Although a child may be immunized with the consent of a parent/guardian or representative, a child is entitled to be informed about immunization and can provide consent to immunization if the person administering the vaccine(s) is sure that the child understands the benefits of, and possible reactions to, each vaccine, and the risk of not getting immunized.

I understand the information provided to me about the vaccine(s) listed above. I understand the benefits of and possible reactions to the vaccine(s) and the risks of not getting immunized. I have had the opportunity to ask questions that were answered to my satisfaction. I understand this consent is valid until **June 30, _____** or until the consent is cancelled, whichever is earlier.

Signature: _____ Date: _____ (dd/mm/yyyy) Print Name: _____

Indicate if you are the ☐ Parent or ☐ Legal Guardian or ☐ Representative or ☐ Above named student (mature minor)

Preferred phone: _____ Text: _____ Email address: _____

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PARENT CONSENT ☐ Phone ☐ Email ☐ Text

From: Relationship to child:

MATURE MINOR CONSENT

I want to be immunized, Mature Minor Consent Signature:

RN Signature: Date: Time:

☐ DPTPO ☐ Tdap
☐ HEPB ☐ MMR
☐ HPV ☐ Varicella
☐ MENC4 ☐ Other: _____
☐ MENCC

OFFICE USE ONLY:

Date Printed: