Hepatitis B Vaccine Consent Form

Instructions for parents

1. Read the back of this paper for information about the hepatitis B vaccine.
2. If you want this student to get the hepatitis B vaccine, complete this form.
3. Return the form to the school office by **September 15, 2017**.

Student information

LAST NAME	FIRST NAME	LANGUAGE SPOKEN AT HOME

BIRTHDAY y / m / d	SCHOOL	ROOM/GRADE

PARENT/GUARDIAN NAME	HOME PHONE	WORK OR CELL PHONE

Student health history

			Please explain any "yes" answers:
Does the student have any allergies?	◯ Yes	◯ No	
Has the student ever had a serious reaction to a vaccine?	◯ Yes	◯ No	
Does the student have a history of fainting or seizures?	◯ Yes	◯ No	
Does the student have a serious medical condition?	◯ Yes	◯ No	

Consent for immunization

I give consent to the Halton Region Health Department to immunize this student with hepatitis B vaccine. This consent applies to all immunization clinics operated by the Halton Region Health Department. The consent is valid for the time period needed to give a complete series of hepatitis B vaccine. I may withdraw my consent in writing. I have read the information about the vaccine or someone has explained it to me. I have had the chance to ask questions. Questions I asked were answered to my satisfaction.

PARENT/GUARDIAN SIGNATURE	DATE

Personal health information is collected to obtain consent to give the student the vaccine(s) listed on this form. The nurses will use the information to make sure it is safe to give the vaccine(s). The Health Department also keeps the information as a record of the vaccine(s) provided. Vaccine records may be shared with the student's health care provider unless you ask us not to. You can refuse to provide information on this form but vaccine(s) may not be given without all information. If you have questions, call 311 to speak to a nurse in the Immunization Services Program of the Halton Region Health Department.

Clinic use only

CLINICAL ASSESSMENT	DOSE 1	NOTES	DOSE 2	NOTES
Do you have a fever or are you sick today?	◯ Yes ◯ No		◯ Yes ◯ No	
Do you have any questions about this vaccine?	◯ Yes ◯ No		◯ Yes ◯ No	
Student health history screening questions have been reviewed.	◯ Yes ◯ No		◯ Yes ◯ No	

Vaccine information

Dose 1 ☐ **Recombivax® 1.0 mL IM**
☐ **Engerix-B® 1.0 mL IM**

◯ Given per current vaccine specific medical directive

DATE	TIME	LOT #	EXPIRY DATE	DELTOID SITE		SIGNATURE
				R	L	

Dose 2 ☐ **Recombivax® 1.0 mL IM**
☐ **Engerix-B® 1.0 mL IM**

◯ Given per current vaccine specific medical directive

DATE	TIME	LOT #	EXPIRY DATE	DELTOID SITE		SIGNATURE
				R	L	

Notes