Porcupine
Health Unit • Bureau de santé

Hepatitis B Vaccine Consent Form

Immunization

Instructions:

1. Read the following information before completing the consent form
   - Dear Parent(s)/Guardian(s) Letter
   - Fact Sheet on the Hepatitis B Vaccine
2. If you want your child to receive the vaccine at the school clinic, **complete SECTION A, B and E.**
3. If your child has already received the Hepatitis B vaccine, **complete SECTION A and C.**
4. If you do not want the Porcupine Health Unit to administer the Hepatitis B vaccine, **complete SECTION D.**

SECTION A

Last Name:	First Name:	Date of Birth: (yy-mm-dd)	Sex: Male ☐ Female ☐
Home Address:	Town:	Home Telephone #:	
Mother's Name & Telephone Number at Work:	Father's Name & Telephone Number at Work:		
School Name:	Room #:		
Doctor:			

SECTION B

☐ **YES**, I consent to have the Porcupine Health Unit administer the Hepatitis B vaccine to my child. I understand this will include 2 shots given within the next 12 to 24 months. I have read the Hepatitis B vaccine fact sheet. I understand the benefits, risks and possible side effects to my child from Hepatitis B vaccination. I understand I can withdraw my consent at any time by calling the Porcupine Health Unit nurse assigned to my child's school. If my child has a serious adverse reaction to the vaccine I will go to a physician immediately and call the Porcupine Health Unit.

Date:____________________ Signature:____________________________________
(yyyy-mm-dd) (Parent/ Legal Guardian)

or

SECTION C

☐ **MY CHILD HAS ALREADY RECEIVED THE HEPATITIS B OR THE TWINRIX VACCINE**

Please provide the dates below.

Date of First Dose:_____________ Date of Second Dose:____________ Date of Third Dose: ______________
(if received)

The nurse assigned to your child's school will call you if more doses are required to complete the hepatitis B series.

Date:____________________ Signature:____________________________________
(yyyy-mm-dd) (Parent/ Legal Guardian)

or

SECTION D

☐ **NO,** I do not consent to have the Porcupine Health Unit administer the Hepatitis B vaccine to my child. I understand the possible consequences if he/she is not vaccinated with the Hepatitis B vaccine.

________________________________ ________________
(Name of Child) (Date of Birth)

Date:______________ Signature:______________________________
(yyyy-mm-dd) (Parent/ Legal Guardian)

SECTION E

Health History	Circle your response		If "yes" briefly describe	Reviewed by nurse before each dose (Please check) 1	2
Did your teenager have a reaction to a vaccine in the past?	Yes	No			
Does your teenager have allergies to the following: • Aluminum, yeast proteins, formaldehyde or latex • Other:________________________________ **Note: There is no antibiotic in this vaccine.**	Yes	No			
Does your teenager have any serious health problems? **ie: seizures, paralysis, history of fainting**	Yes	No			
Is your teenager taking any medication that may lower his/her immune system, such as cancer therapy?	Yes	No			
Is your teenager pregnant or is there a chance she could become pregnant during the following months?	Yes	No			

Personal health information on this form is collected by the Porcupine Health Unit for the Vaccine Preventable Disease Program. For information about the way we protect the confidentiality of personal health information, call us or visit Porcupine Health Unit's Privacy Statement at **www.porcupinehu.on.ca**.

FOR NURSE'S USE ONLY

Student's Last Name:	Student's First Name:	Date of Birth: (yy-mm-dd)

Date & Time Vaccine Given (yy-mm-dd)	Trade name of the product / Disease against which it protects	Dosage & Route	Site (circle)	Manufacturer	Lot # / Expiry Date (yy-mm)	Nurse's Signature & Title
Date of Dose # 1 :	Recombivax HB® Engerix® - B	1.0 mL / IM	Left deltoid Right deltoid	Merck Frosst Canada Ltd. GSK		
Time :	Hepatitis B					
Date of Dose # 2 :	Recombivax HB® Engerix® - B	1.0 mL / IM	Left deltoid Right deltoid	Merck Frosst Canada Ltd. GSK		
Time :	Hepatitis B					

Comments:

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