COUNTY OF LAMBTON

COMMUNITY HEALTH SERVICES DEPARTMENT

Environmental Health & Prevention Services
160 Exmouth Street
Point Edward, ON N7T 7Z6
Telephone: 519 383-8331
Toll Free: 1-800-667-1839
Fax: 519 383-7092
www.lambtonhealth.on.ca

Human Papilloma Virus (HPV)
Vaccine Consent form
(for Grade 8 females only)

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

Birth Date: (Year)_____ (Month)_____ (Day)_____

Ontario Health Card Number:_____

School Name:_____ **Grade:**_____ **Class:**_____

Please print clearly and complete the appropriate section(s).

YES, I consent to have the Community Health Services Department administer the Human Papilloma Virus (HPV) vaccine to my daughter, _____ to complete her HPV vaccination series. This will include up to 3 shots given within the next 12 to 24 months. I have read the Community Health Services Department's HPV vaccine fact sheet. I understand the benefits, risks, and possible side effects to my child from HPV vaccination. I understand I can withdraw my consent at any time. If my child has a serious adverse reaction to the vaccine, I will go to a physician immediately and call the Community Health Services Department.

Date: _____ Signature:_____
yyyy/mm/dd (Parent/Legal Guardian)

Daytime Telephone Number :(_____)_____

OR

MY DAUGTER HAS ALREADY RECEIVED THE HPV VACCINE (e.g. Gardasil ®)
Please provide the dates below. Three shots are required for full protection. If your daughter has not received all three shots, please sign the above consent form to ensure she is fully protected.

Date of First Dose _____
Date of Second Dose _____
Date of Third Dose _____

If your daughter has received 3 doses, no additional doses are required at this time.

OR

NO. I do not consent to have the Community Health Services Department administer the HPV vaccine to my daughter _____. I understand the possible consequences if she is not vaccinated with the HPV vaccine.

Date: _____ Signature:_____
yyyy/mm/dd (Parent/Legal Guardian)

Please call the Immunization Information Line at 519 383-8331 ext. 3589 if your child receives the Human Papilloma Virus (HPV) vaccine in the future from another health care provider or if you require further information.

This information is collected under the authority of the **Health Protection and Promotion Act, R.S.O. c.H.7** and under the **Immunization of School Pupils Act** for the purpose of maintaining an immunization record for this student.

Cancer Care Ontario (CCO) is collecting information on the Human Papilloma Virus immunization status of individuals receiving the publicly funded HPV vaccine. Immunization information will be provided to CCO for evaluation purposes unless you specifically request the Community Health Services Department to withhold this information.

For more information please contact:
Environmental Health and Prevention Services Team
Telephone: 519 383-8331
Toll Free: 1-800-667-1839

Adapted from Toronto Public Health
09 2007

FOR NURSE'S USE ONLY

Human Papilloma Virus (HPV) Vaccine for Grade 8 Females

Grade 8 female: ☐ yes ☐ no HPV vaccine required: ☐ yes ☐ no
Doses required: ☐ 1 ☐ 2 ☐ 3

Assessment nurse:_____ Date:_____

NURSING ASSESSMENT QUESTIONS	DOSE ONE	DOSE TWO	DOSE THREE
1. Have you received needles for Human Papilloma virus (HPV) immunization before today?	☐ yes ☐ no	**Dose One Date Checked Adequate Spacing Evident (≥ 30 days)** ☐ yes ☐ no Initials_____	**Dose Two Date Checked Adequate Spacing Evident (≥ 90 days)** ☐ yes ☐ no Initials_____
2. Have you ever had a reaction to any immunization in the past?	☐ yes ☐ no		
3. Did you have a reaction to the first/second Human Papilloma Virus (HPV) needle?		☐ yes ☐ no	☐ yes ☐ no
Did you receive any Human Papilloma Virus needle since your last dose?		☐ yes ☐ no	☐ yes ☐ no
4. Did you understand what the needle is for?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
5. Are you allergic to the following: i) aluminium ii) yeast iii) sodium chloride iv) other Note: there is NO antibiotic, preservative, latex or thimerosal in this vaccine.	☐ yes ☐ no ☐ yes ☐ no ☐ yes ☐ no _____	☐ yes ☐ no ☐ yes ☐ no ☐ yes ☐ no _____	☐ yes ☐ no ☐ yes ☐ no ☐ yes ☐ no _____
6. Are you sick today with anything more than a cold?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Do you have a fever?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
7. Do you have any serious health problems, i.e. seizures, paralysis, history of fainting?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Are you taking any medication that may lower your immune system, such as cancer therapy?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
8. Do you think you might be pregnant?	☐ yes ☐ no	☐ yes ☐ no	☐ yes ☐ no
Nursing Notes:	Vaccine: Gardasil ® Dose: 0.5 ml Lot# _____ R / L deltoid Route: IM Date:_____ Time_____ _____ Signature of Nurse [ ] Preloaded syringe [ ] Self Loaded [ ] Loaded by: _____	Vaccine: Gardasil ® Dose: 0.5 ml Lot# _____ R / L deltoid Route: IM Date:_____ Time_____ _____ Signature of Nurse [ ] Preloaded syringe [ ] Self Loaded [ ] Loaded by: _____	Vaccine: Gardasil ® Dose: 0.5 ml Lot# _____ R / L deltoid Route: IM Date:_____ Time_____ _____ Signature of Nurse [ ] Preloaded syringe [ ] Self Loaded [ ] Loaded by: _____