



**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

**NURSES USE ONLY**

See Reverse for Additional Comments

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**Meningococcal Vaccine: Menactra™  
(Conjugate A, C, Y, W-135)  
Consent Form**

Student's Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_

Date of Birth: (Year) \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ Age \_\_\_\_\_ M  F  School: \_\_\_\_\_

Phone number: \_\_\_\_\_ Parent/Guardian's business number: \_\_\_\_\_

Street Address \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Health Card Number: \_\_\_\_\_

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**Parent/Guardian to fill out please:**

- |  |                             |                              |  |
|--|-----------------------------|------------------------------|--|
| Has your child ever had an allergic reaction to a vaccine? | No <input type="checkbox"/> | Yes <input type="checkbox"/> | If yes, please explain below                       |
| Is your child allergic to any of the following:            |                             |                              |  |
| Aluminum   | No <input type="checkbox"/> | Yes <input type="checkbox"/> | If yes, please explain below                       |
| Tetanus vaccine (contained in NeisVac-C™)                  | No <input type="checkbox"/> | Yes <input type="checkbox"/> | If yes, please explain below                       |
| Diphtheria vaccine (contained in Menjugate™)               | No <input type="checkbox"/> | Yes <input type="checkbox"/> | If yes, please explain below                       |
| Is there a possibility that your child is pregnant?        | No <input type="checkbox"/> | Yes <input type="checkbox"/> | If yes, please explain below                       |
| Does your child have a bleeding disorder?                  | No <input type="checkbox"/> | Yes <input type="checkbox"/> | If yes, please explain below                       |
| Has your child ever had a meningococcal vaccine before?    | No <input type="checkbox"/> | Yes <input type="checkbox"/> | If yes, please indicate date and product, if known |

Please explain any "Yes" answers included above:

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I have read and understand the "Meningococcal Vaccine: Menactra™ (Conjugate A,C, Y, W-135) Fact sheet". I have had the chance to ask questions and understand the answers provided to me. I consent to receiving the Menactra vaccine. I am aware that personal health information collected on this form may be released to my physician, other health units, or hospital. This is done to ensure that vaccines are administered at the right time and are not given more often than needed.

**Signature of Parent/Guardian:** \_\_\_\_\_ **Print name:** \_\_\_\_\_

**Date of signature:** \_\_\_\_\_

The personal information on this form is collected under the authority of the Health Protection and Promotion Act, R.S.O. 1990, c. H.7. Please direct any questions about the collection of this information to the Community Health Services Department - 519 383-8331.

## Nursing Documentation

Are you feeling sick on the day of the clinic:  
Do you have any allergies:

No  Yes   
No  Yes  \_\_\_\_\_

### For Clinic Use:

Vaccine	Dose	Site	Lot Number	Date Given	Time Given	Given By
Menactra™	0.5 mL IM	L or R deltoid				

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_