TORONTO Public Health

Meningococcal (Men ACYW-135) Vaccine Consent Form

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

Birth date: (Year)_____ (Month)_____(Day)_____ **Sex:** ❑ Male ❑ Female

Ontario Health Card Number (if available):_____

School Name:_____ **Class:**_____

Parents:

a) Please complete either the **YES** or **NO** section.

b) Write down if your child has already received a meningococcal "meningitis" vaccine.

YES, I consent to have Toronto Public Health administer one dose of Meningococcal (Men ACYW-135) vaccine to my child _____ . I have read the Toronto Public Health Meningococcal (Men ACYW-135) fact sheet. I understand the benefits, risks and possible side effects to my child from vaccination with Meningococcal (Men ACYW-135). I understand I can withdraw my consent at any time. If my child has an adverse reaction to the vaccine I will go to a physician immediately and contact Toronto Public Health. Only one dose of this vaccine is required to protect my child at this time.

Date: _____ **Signature:** _____ **Day phone #**_____
yyyy/mm/dd (Mother / Father / Legal Guardian)

OR ----------

MY CHILD HAS ALREADY RECEIVED THE FOLLOWING Meningococcal meningitis vaccine(s):

Menomune® _____ (date vaccine given)

Men AC® _____ (date vaccine given)

MENACTRA® _____ (date vaccine given)

Menjugate®/NeisVac-C®/Meningitec® _____ (date vaccine given)

OR ----------

NO, I do not consent to have Toronto Public Health administer the **Meningococcal (Men ACYW-135)** vaccine to my child _____. I understand the possible consequences if my child is not vaccinated.

Date: **Signature:**

Call the Immunization Information Line at 416-392-1250:

- If your child receives meningococcal vaccine in the future from another health care provider
- If you need more information about this vaccine

Personal health information on this form is collected under the authority of the Health Protection and Promotion Act, R.S.O. 1990, c. H. 7. It is used for the Toronto Public Health Vaccine Preventable Diseases Program. **The confidentiality of this information is protected.** For more information, visit our Privacy Statement at www.toronto.ca/health/information_practice_statement.htm **or** contact Manager, Vaccine Preventable Diseases - 850 Coxwell, Avenue, Toronto, ON, M4C 5R1 or by telephone: 416 392-1250.

FOR NURSE'S USE ONLY

Meningococcal (Men ACYW-135) **vaccine required : ❑ yes ❑ no**

Nursing Assessment Questions	
1. Have you received needles for Meningococcal (Men ACYW-135) immunization before today?	❑ yes ❑ no
2. Have you ever had a reaction to any immunization in the past?	❑ yes ❑ no
3. Do you understand what the needle is for?	❑ yes ❑ no
4. Are you allergic to the following: i/ Latex ii/ Diptheria Toxoid iii/ Other	❑ yes ❑ no ❑ yes ❑ no ❑ yes ❑ no _____
5. Have you ever been diagnosed with Guillain-Barre Syndrome (GBS) (note: GBS is a neurological disorder that causes muscle paralysis)	❑ yes ❑ no
6. Are you sick today with anything more than a cold? Do you have a fever?	❑ yes ❑ no ❑ yes ❑ no
7. Do you have any serious health problems, i.e. seizures, paralysis, history of fainting? Are you taking any medication that may lower your immune system, e.g. anti-cancer agent?	❑ yes ❑ no ❑ yes ❑ no Comments:
8. Do you think you might be pregnant?	❑ yes ❑ no
Nursing Notes:	**Vaccine**: MENACTRA® Dose:**0.5 ml** Other:_____ Lot #_____ R / L deltoid Route: __IM___ Date:_____ Time:_____ _____ Signature of Nurse