



CONSENT FOR MMR IMMUNIZATION

USE A PEN, PRINT CLEARLY AND PRESS FIRMLY

SECTION 1: CHILD'S PERSONAL INFORMATION

LAST NAME		FIRST NAME		SCHOOL		DIV/TEACHER	
GENDER <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (YYYY / MM / DD)	CARECARD NUMBER		NAME OF PARENT / GUARDIAN / REPRESENTATIVE		RELATIONSHIP TO CHILD	
DAY PHONE		EVENING PHONE		CELL PHONE		HAS YOUR CHILD EVER HAD A SERIOUS OR LIFE-THREATENING ALLERGIC REACTION? <input type="checkbox"/> NO <input type="checkbox"/> YES (TO WHAT?)	

SECTION 2: PARENT / GUARDIAN / REPRESENTATIVE CONSENT

For the vaccine listed below, check Yes or No, sign and date.
 I understand the information in the HealthLink BC file for the vaccine listed below. I understand the benefits and possible reactions for the vaccine and the risk of not getting immunized. I have had the opportunity to ask questions. I understand this consent is valid for the vaccine listed below unless the consent is cancelled.
I consent for my child to receive the following vaccine:

MMR vaccine	SIGNATURE	DATE (YYYY / MM / DD)
I want my child immunized. <input type="checkbox"/> YES <input type="checkbox"/> NO		
Has your child had MMR vaccine? If yes, give date(s), (YYYY/MM/DD): Dose #1 _____ Dose #2 _____		
If your child has any medical conditions that affect the immune system, contact your local Health Unit prior to immunization.		

SECTION 3: PUBLIC HEALTH USE ONLY – MATURE MINOR OR TELEPHONE CONSENT

MATURE MINOR CONSENT			
STUDENT SIGNATURE	FOR MMR vaccine <input type="checkbox"/> YES <input type="checkbox"/> NO	NURSE'S SIGNATURE	DATE (YYYY / MM / DD)
TELEPHONE CONSENT			
TELEPHONE CONSENT OBTAINED FROM	FOR MMR vaccine <input type="checkbox"/> YES <input type="checkbox"/> NO	NURSE'S SIGNATURE	DATE (YYYY / MM / DD)
RELATIONSHIP TO CHILD			

SECTION 4: PUBLIC HEALTH USE ONLY – CHILD'S IMMUNIZATION RECORD

		DATE GIVEN (YYYY / MM / DD)	SITE		LOT #	PROVIDER SIGNATURE
MMR vaccine	1 st DOSE		LA	RA		
	2 nd DOSE		LA	RA		
NURSE'S NOTES						

Personal information collected on this form will be used by the health authority to update the student's immunization record. The information will be used and disclosed in accordance with the *Freedom of Information and Protection of Privacy Act*. Summary statistical information may be reported to the Ministry of Health Services. If you have any questions about the collection and use of this personal information, contact your local public health nurse. You may be contacted to request your participation in the evaluation of this school immunization program.