MENACTRA®, MENINGOCOCCAL (Groups A, C, Y, and W-135) POLYSACCHAIRIDE DIPHTHERIA TOXOID CONJUGATE VACCINE CONSENT FORM

SECTION 1: CHILD'S PERSONAL INFORMATION

STUDENT NAME: (Last)	STUDENT NAME: (First Name)	BIRTH DATE: (yyyy / mm / dd)	GENDER:
		/ /	☐ M ☐ F

BC CARECARD NUMBER:	NAME OF PARENT / GUARDIAN / REPRESENTATIVE:	RELATIONSHIP TO CHILD

DAY PHONE:	EVENING PHONE:	CELL PHONE:	SCHOOL:

PHYSICIAN NAME:	PHYSICIAN ADDRESS:

ALERT: HAS YOUR CHILD EVER HAD A SERIOUS OR LIFE-THREATENING ALLERGIC REATION TO A VACCINE BEFORE?

☐ NO ☐ YES, (TO WHAT?):

It is recommended that parents/guardians or representatives and their children discuss consent for immunization. Efforts are first made to seek parental/guardian or representative consent prior to immunization. However, children under the age of 19, who are able to understand the benefits and possible reactons for vaccine and the risk of not getting immunized, can legally consent to or refuse immunizations.

SECTION 2: PARENT / GUARDIAN / REPRESENTATIVE CONSENT

YES, I consent to have my child_____ to have one dose of Meningococcal vaccine ACYW-135 (Menactra®). I have read and understand the information on the Immunize BC and HealthLink BC File for the vaccine Meningococcal Vaccine (Men ACYW-135) fact sheet. I understand the benefits and possible reactions of the vaccine and the risk of not getting immunized. I have had the opportunity to ask questions that were answered to my satisfaction. I understand this consent is valid for the vaccine unless the consent is cancelled.

DATE: (YYYY/ MM / DD)	SIGNATURE:
/ /	

OR , My Child has already received Menactra®, Menveo® or Nimenrix® _____ .
(DATE: YYYY / MM / DD)

NOTE: If your child has had a different meningitis vaccine like MEN-C in Grade 6, your child should still get the booster dose of Menactra® for greater protection against meningitis for age groups 15 - 24 (sign consent above).

NO, I do not consent to have my child _____ immunized for Meningococcal vaccine ACYW-135 Menactra®. I understand the possible consequences if my child is not vaccinated.

DATE: (YYYY/ MM / DD)	SIGNATURE:
/ /	

SECTION 3: TELEPHONE OR MATURE MINOR CONSENT

TELEPHONE CONSENT OBTAINED FROM	FOR MCV4 Vaccine	MCV4 REPRESENTATIVE Name	DATE: (YYYY/MM/DD)
RELATIONSHIP TO CHILD	☐ YES ☐ NO	MCV4 REPRESENTATIVE SIGNATURE	/ /

MATURE MINOR CONSENT

STIDENT SIGNATURE	FOR MCV4 Vaccine	MCV4 REPRESENTATIVE Name	DATE: (YYYY/MM/DD)
STUDENT NAME (PRINT CLEARLY)	☐ YES ☐ NO	MCV4 REPRESENTATIVE SIGNATURE	/ /

Personal information collected on this form will be used by the immunizer and the student's physician named on this form for immunization and record purposes. The information will be used and disclosed in accordance with the Freedom of Information and Protection of Privacy Act.

FOR IMMUNIZER'S USE ONLY

1. Do you understand what Meningococcal needle is for?	☐ YES	☐ NO
2. Have you received needles for Meningococcal ACYW-135 (Menveo®, Menactra®, Nimenrix®) immunization before today?	☐ YES	☐ NO
3. Have you ever had a reaction to a vaccine?	☐ YES	☐ NO
4. Are you allergic to the following:		
a) Latex	☐ YES	☐ NO
b) Diptheria Toxiod	☐ YES	☐ NO
c) Other _____ _____	☐ 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?	☐ YES	☐ NO
8. Are you taking any medication that may lower your immune system, e.g. anti-cancer agent?	☐ YES	☐ NO
9. Do you think you might be pregnant?	☐ YES	☐ NO

IMMUNIZER'S NOTES:

VACCINE: MENACTRA®

Dose: 0.5 ml Routie: IM

Lot #: _____

☐ Left Deltiod ☐ Right Deltoid

Date: _____ Time: _____

Signature of Immunizer

☐ Self Loaded ☐ Loaded by: _____

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