Agence de la santé et des services sociaux de Montréal
Québec
Direction de santé publique

Centre intégré universitaire de santé et de services sociaux de l'Ouest-de-l'Île-de-Montréal
Québec

CLSC file no : _____

Homeroom:_____

AUTHORISATION FOR VACCINATION, SECONDARY 3, 2017-2018

Diptheria - Whooping Cough - Tetanos (*dTap*) / HPV / CHickenpox / Meningitis C / Other

School- John Rennie High School

❑ *CLSC Pierrefonds*
❑ *CLSC Lac-Saint-Louis*

✓ THE STUDENT TO BE VACCINATED MUST BRING **THE COMPLETED AND SIGNED FORM AND HIS OR HER VACCINATION BOOKLET,** WHETHER THE VACCINATION IS ACCEPTED OR NOT

1. IDENTIFICATION OF THE PERSON TO VACCINATE (in block letters)

Last name:	**First name:**	**SEX** ☐ M ☐ F	**Date of birth:** ____ / ____ / ____ Year Month Day
Health insurance number			**Expiry Date:** ____ / ____ Year Month

Address: Postal code

Father's last name: **Father's first name:** ☎ ___-___-____

Mother's last name: **Mother's first name:** ☎ ___-___-____

2. MEDICAL INFORMATION ABOUT THE PERSON TO VACCINATE

Has the person to be vaccinated:

1. ever had varicella (**chickenpox**) or the (Varivax, Priorix Tetra or Pro Quad) vaccine **after one year** old?
   UNKNOWN ☐ NO ☐ YES ☐ Date: _____
2. received two doses of Measles vaccine (MMR, RRO, Priorix, Priorix Tetra or Pro Quad) (**after the age of one year old?**
   UNKNOWN NO ☐ YES ☐ Dates : # 1_____ #2 _____
3. received **tetanus vaccine** (Boostrix , Adacel, or dTap) in the past 5 years (*e.g. booster or following an injury*?)
   NO ☐ YES ☐ Date: _____
4. received a **meningitis vaccine** (Menjugate, Menactra, Meningitec, Bexsero)**at age 10, or older** ?
   NO ☐ YES ☐ Date:_____
5. ever had a serious allergic reaction that required emergency medical care? NO ☐ YES ☐
   ↳ if yes, specify to what: _____
6. have an immune system problem (*leukaemia, chemotherapy, other*) NO ☐ YES ☐
7. received a blood transfusion or immune globulin injection in the past 11 months? NO ☐ YES ☐
   ↳ if yes, which one(s): _____

3. CONSENT

I am the person who can get vaccinated or the parent or guardian of a child under 14 years of age. I have read the information on the diseases, vaccines and side effects included with this form. If needed, I have contacted the school nurse, or my CLSC to get answers to my questions.

BOYS and GIRLS:
Consent (or refusal) for vaccination, please check the appropriate boxes:

- ❑ I consent ❑ I refuse vaccination against **diphtheria, pertussis and tetanus (*dTap*) (1 dose)**
- ❑ I consent ❑ I refuse vaccination against **meningitis C (1dose)**
- ❑ I consent ❑ I refuse **any other vaccine necessary** to update my vaccination status in accordance with the recommendations in the Protocole d'Immunisation du Québec (*Measles – Rubella – Mumps, Varicella, (chicken pox), Hepatitis **B**, Poliomyelitis*)

GIRLS ONLY:

Consent (or refusal) for vaccination, please check the appropriate boxes:

- ❑ **Previous HPV** vaccinations: date (Y-M-D) of **dose #1** _____ **dose#2**_____ (dose#3_____)
- ❑ I consent ❑ I refuse vaccination against human papilloma virus (HPV – 3 doses)

X / /

Signature of the individual, if aged 14 or over, (or of parent/guardian, if under 14) Year Month Day

#

SECTION RÉSERVÉE AUX VACCINATEURS

RÉVISION DE LA COUVERTURE VACCINALE (Cocher la case si vaccination à jour pour l'âge)

1ère visite Carnet : Oui ❑ Non ❑ - **2e visite** Carnet : Oui ❑ Non ❑ - **3e visite** Carnet : Oui ❑ Non ❑

DCaT	Polio	Rougeole	Rubéole	Oreillons	Hép B	Méningo	VPH (X2 9 - 13a)	Protégé varicelle	Statut complet
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

À compléter le jour de la vaccination :

	1ère visite	*2e visite*	*3e visite ou rattrapage*
Revalider la section 2.	Contre-indication à la vaccination ? non ☐ oui ☐ _____	Contre-indication à la vaccination ? non ☐ oui ☐ _____	Contre-indication à la vaccination ? non ☐ oui ☐ _____
VACCINS ADMINISTRÉS			
SVP inscrire la mention **DV** si l'élève est déjà vacciné ou immunisé et inscrire la date du vaccin.	☐ Boostrix 0,5 ml IM BG ☐ BD ☐ no de lot: _____	☐ Boostrix 0,5 ml IM BG ☐ BD ☐ no de lot: _____	☐ _____ _____ BG ☐ BD ☐ no de lot: _____
SVP inscrire la mention **DV** si l'élève est déjà vacciné ou immunisé (vaccin reçu à l'âge de 10 ans ou après) et inscrire la date du vaccin.	☐ Menjugate 0,5 ml IM BG ☐ BD ☐ no de lot: _____	☐ Menjugate 0,5 ml IM BG ☐ BD ☐ no de lot: _____	☐ _____ _____ BG ☐ BD ☐ no de lot: _____
SVP inscrire le numéro de la dose administrée (**1-2-3**)	☐ Gardasil 0,5 ml IM BG ☐ BD ☐ no de lot: _____ #	☐ Gardasil 0,5 ml IM BG ☐ BD ☐ no de lot: _____ #	☐ Gardasil 0,5 ml IM BG ☐ BD ☐ no de lot: _____ #
Autres	☐ _____ _____ BG ☐ BD ☐ no de lot: _____ #	☐ _____ _____ BG ☐ BD ☐ no de lot: _____ #	☐ _____ _____ BG ☐ BD ☐ no de lot: _____ #
Autres	☐ _____ _____ BG ☐ BD ☐ no de lot: _____ #	☐ _____ _____ BG ☐ BD ☐ no de lot: _____ #	☐ _____ _____ BG ☐ BD ☐ no de lot: _____ #
Signature du vaccinateur			
Signature de l'infirmière			
Date et heure			
Vaccination complétée	☐ OUI ☐ NON	☐ OUI ☐ NON	☐ OUI ☐ NON

Vaccins manquants	Vaccins	Nombre de dose	Vaccins	Nombre de dose	Vaccins	Nombre de dose
	☐ DCaT		☐ DCaT		☐ DCaT	
	☐ Polio		☐ Polio		☐ Polio	
	☐ RRO		☐ RRO		☐ RRO	
	☐ Hep B		☐ Hep B		☐ Hep B	
	☐ Varicelle		☐ Varicelle		☐ Varicelle	
	☐ Men C		☐ Men C		☐ Men C	
	☐ VPH		☐ VPH		☐ VPH	