

CONSENT FORM FOR HEPATITIS B IMMUNIZATION

Student's Name: _____
LAST FIRST

Sex: Male Female Birth Date: _____
YEAR MONTH DAY

Health Card #: _____

School: _____ Room: _____

CONSENT FOR IMMUNIZATION

I have read or had explained to me this information about the vaccine. Any questions I had, have been answered to my satisfaction. **There has been no serious allergic reaction to a vaccine, or a reaction to thimerosal (mercury - a preservative in vaccines), aluminum, yeast, or latex.**

I ASK THAT THE ABOVE NAMED BE VACCINATED AGAINST HEPATITIS B (TWO DOSES)

Date: _____ Allergies: _____

Parent/Legal Guardian Signature: _____

Print Name: _____

Phone: (Home) _____ - _____ - _____ (Bus) _____ - _____ - _____

Unless cancelled, this request is valid for the time period needed to give both doses of the vaccine, or a maximum of one school year.

HEPATITIS B

IMMUNIZATION RECORD

If the student has already been immunized for Hepatitis B, please give dates: 1. _____
YEAR MONTH DAY

Note: Hepatitis B is not to be confused with Hib (Haemophilus Influenzae b) 2. _____
YEAR MONTH DAY

3. _____
YEAR MONTH DAY

This information is collected under the authority of sections 2 and 5 of the Health Protection and Promotion Act and Ont. Reg. 585/94 under the Health Cards and Numbers Control Act and Section 11 under the Immunization of School Pupils Act for the purpose of maintaining an immunization record for this student. For more information, contact the Freedom of Information Coordinator at your public health unit.



Windsor-Essex County Health Unit
 1005 Ouellette Avenue, Windsor, ON N9A 4J8
 519-258-2146 ext. 1222
 www.wehealthunit.org

FOR NURSE'S USE ONLY

Dose #1 Allergies to thimerosal, mercury, aluminum, or yeast?

Yes No Nurse's Initials _____

Immunized as per standard of care.

VACCINE **Recombivax HB** _____ 1 ml intramuscular

Right/Left _____
DELTOID DATE TIME LOT#

Nurse's Signature: _____

Dose #2 Allergies to thimerosal, mercury, aluminum, or yeast?

Yes No Nurse's Initials _____

Immunized as per standard of care.

VACCINE **Recombivax HB** _____ 1 ml intramuscular

Right/Left _____
DELTOID DATE TIME LOT#

Nurse's Signature: _____

Nurse's Notes:

