CONSENT FORM
FOR MENINGITIS C 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 aluminum.**

I ASK THAT THE ABOVE NAMED BE VACCINATED AGAINST MENINGITIS C

Date: _____ Allergies: _____

Parent / Legal Guardian : _____

Please Print Name: _____

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

Unless cancelled, this request is valid for one school year.

MENINGITIS C
IMMUNIZATION RECORD

If the student has already been immunized for Meningitis C, please give date: _____
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
Unité sanitaire de Windsor-comté d'Essex
WINDSOR · ESSEX · LEAMINGTON
www.wechealthunit.org

Windsor-Essex County Health Unit
1005 Ouellette Avenue, Windsor, ON N9A 4J8
519-258-2146 ext. 1222
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FOR NURSE'S USE ONLY

Dose #1 Allergies to aluminum or Diphtheria toxin?

❑ Yes ❑ No Nurse's Initials _____

Immunized as per standard of care.

VACCINE **NeisVac C** 0.5 ml intramuscular

Right/Left _____
DELTOID DATE TIME LOT#

Nurse's Signature: _____

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Nurse's Notes: