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

File N° *(to be used by the CLSC)*			
User name and surname			
Date of birth	Year	Month	Day
Health Insurance N°	Expiration	Year	Month
Address			
City	Postal Code		

CONSENT FORM
GRADE 9 VACCINATION
2024-2025 COHORT

- ***Fill in the form, including the box above, with a pen.***
- ***Sign the form (A student who is 14 years old or more has to sign their own form).***

A. ADDITIONAL INFORMATION OF THE STUDENT TO BE VACCINATED

School Name :	Permanent code :	Group/Homeroom :
Last name at birth, first name of parent 1 :	Last name at birth, first name of parent 2 :	Last name at birth, first name of guardian :

Phone number (Where you can be reached) :

B. MEDICAL HISTORY OF THE STUDENT TO BE VACCINATED

		Yes	No
1.	Ever had a serious allergic reaction following the administration of a vaccine that required emergency medical care ? If yes, please specify:	❍	❍
2.	Ever had a serious reaction following the administration of a vaccine, or has a contraindication to a vaccine? If yes, please specify :	❍	❍
3.	Has serious health problems (severe allergies, seizures, low platelets, etc.)? If yes, please specify:	❍	❍
4.	Has an immune system problem due to an illness, or is taking medications that weaken the immune system? (Cancer, leukemia, HIV/AIDS, bone marrow graft? If yes, please specify:	❍	❍
5.	Takes medication that contains acetylsalicylic acid (aspirin)?	❍	❍
6.	Has received blood products (ex. Blood transfusion, immunoglobulin injection) in the last 11 months?	❍	❍
7.	Received a dose of the measles vaccine after the age of one year old? If yes, **please include vaccination record. Dates of the MEASLES vaccination : #1 #2**	❍	❍
8.	Previously had the chickenpox (varicella) infection? If yes, in what year or at what age?	❍	❍
9.	Other considerations that may affect the vaccination of the student? If yes, please specify:	❍	❍

C. CONSENTEMENT

If your child is under the age of 14, as the parent or tutor, your consent is required for vaccination. If you are 14 years old or over, you can consent yourself to received health care services, vaccination included.

The student's vaccination record/record will be analyzed to determine whether the vaccines consented to are recommended. **The student will not be administered any vaccines for which they are up to date.** If no proof of vaccination is available, it is assumed that the student did not receive the vaccine(s) and we will recommend that they receive them on the day of vaccination.

The vaccines used are provided by the Ministry of Health and Social Services (MSSS) and we are not able to provide specific brands.

If you have any questions, we invite you to contact your local community service center (CLSC) or school nurse.

❍ I consent ❍ I refuse The vaccination against **Diphtheria and Tetanus** (+ *polio and/or whooping cough, if needed*)
→ One (1) dose between 14 and 16 years old is recommended.

❍ I consent ❍ I refuse The vaccination against **Meningococcal serogroup Men-C-ACWY**
→ One (1) dose after the age of 10 years old is recommended.

❍ I consent ❍ I refuse The vaccination against **Hepatitis B**
→ Two (2) to three (3) doses of Hepatitis B are recommended.

❍ I consent ❍ I refuse **Any other vaccines necessary** to bring up to date my vaccination status according to the Protocole d'immunisation du Québec (*HPV – Measles – Mumps – Rubella – Varicella – Hepatitis A*)

Signature : _____ Date : _____

☐ of the student 14 years old or over ***or*** ☐ of the parent/guardian if student is under 14 years old

SECTION RÉSERVÉE AUX VACCINATEURS

RÉVISION DE L'HISTORIQUE VACCINAL (pré-vaccination) - indiquer le nombre de doses manquantes si pas à jour

ID SI-PMI :

☐ Double identification	☐ Carnet de vaccination	☐ Vérification du SI-PMI	☐ Primo-vaccination

dT	dcaT	Polio	RRO	HA	HB	Men-ACWY	Varicelle	VPH	Statut vaccinal
☐ à jour ☐ ____ doses	☐ à jour ☐ ____ doses	☐ à jour ☐ ____ doses	☐ à jour ☐ ____ doses	☐ à jour ☐ ____ doses	☐ à jour ☐ ____ doses	☐ à jour ☐ ____ doses	☐ à jour ☐ ____ doses	☐ à jour ☐ ____ doses	☐ à jour

ÉVALUATION

Présente une maladie aigue, modérée, ou grave, avec ou sans fièvre?	Tº C (le cas échéant) :	☐ Oui	☐ Non
A reçu un vaccin ou fait un test TCT dans les 4 dernières semaines?		☐ Oui	☐ Non
Est enceinte ?		☐ Oui	☐ Non
A une contre-indication à une vaccination? Si oui, préciser.		☐ Oui	☐ Non
Information / Bénéfices et effets secondaires expliqués?		☐ Oui	☐ Non
Attente x 15 min demandé ?		☐ Oui	☐ Non

Commentaires :

_____

_____

_____

DÉCISION DE L'INFIRMIÈRE

Administrer les vaccins suivants :

dT	dcaT-Polio	Men-C-ACWY	HB	HA	VPH	RRO	Var
☐	☐	☐	☐	☐	☐	☐	☐

Cordonnées de l'infirmière évaluatrice

Nom Complet : Titre :

Signature : Permis :

VACCINS À ADMINISTRER

❑ Double identification (Si infirmière évaluatrice et vaccinatrice différentes)

Vaccin	No de Lot	Dose	Site
☐ Td Absorbée (dT) ☐ Adacel-Polio (dcaT-Polio)		☐ Contenu du vial IM / Contenu de la seringue IM	☐ BG ☐BD
☐ Nimenrix (Men-C-ACWY)		☐ Contenu de la seringue IM	☐ BG ☐BD
☐ Engerix (HB) ☐ Vaqta / Havrix (HA) ☐ Twinrix (HAHB)		☐ Contenu du vial IM / Contenu de la seringue IM	☐ BG ☐BD
☐ Gardasil-9 (VPH)		☐ Contenu de la seringue IM	☐ BG ☐BD
☐ MMR-II / Priorix (RRO) ☐ Varivax-III (Var) ☐ Proquad (RRO-Var)		☐ Contenu du vial SC	☐ BG ☐BD

Date d'administration: **Heure :**

Coordonnées de l'infirmière vaccinatrice

Nom Complet : Titre :

Signature : Permis :

VACCINATION COMPLÉTÉE

☐ **OUI** - statut vaccinal à jour
☐ **NON** - lettre « vaccination manquante » remise. Complétez le tableau ci-dessous.

VACCINS MANQUANTS APRÈS LA CLINIQUE D'AUJOURD'HUI

dT	dcaT	Polio	Men-C-ACWY	HB	HA	VPH	RRO	Varicelle
☐ à jour ☐ ____ doses	☐ à jour ☐ ____ doses	☐ à jour ☐ ____ doses	☐ à jour ☐ ____ doses	☐ à jour ☐ ____ doses	☐ à jour ☐ ____ doses	☐ à jour ☐ ____ doses	☐ à jour ☐ ____ doses	☐ à jour ☐ ____ doses

Saisie SI-PMI (Initiale) ☐