BRITISH COLUMBIA | Ministry of Health

CONSENT FOR MEASLES, MUMPS, RUBELLA, VARICELLA IMMUNIZATION

LAST NAME		FIRST NAME	SCHOOL		DIV / TEACHER
GENDER (SPECIFY)	BIRTHDATE (YYYY / MM / DD)	PERSONAL HEALTH NUMBER (PHN)	NAME OF PARENT / GUARDIAN / REPRESENTATIVE		RELATIONSHIP TO CHILD

HOME PHONE	CELL PHONE	ALERT	HAS YOUR CHILD EVER HAD A SERIOUS OR LIFE-THREATENING ALLERGIC REACTION? ☐ NO ☐ YES (TO WHAT?):
ALTERNATE PHONE(S)			IS YOUR CHILD'S IMMUNE SYSTEM AFFECTED BY A SEVERE DISEASE OR MEDICATION? ☐ NO ☐ YES

PARENT / GUARDIAN / REPRESENTATIVE – For the vaccines listed below, check Yes or No, sign and date.
I understand the information in the HealthLinkBC File for the vaccines listed below. I understand the benefits and possible reactions for the vaccines and the risk of not getting immunized. I understand that in the rare occurrence of anaphylaxis, emergency treatment will be provided. I have had the opportunity to ask questions that were answered to my satisfaction. I understand this consent is valid for two years for the vaccines listed below unless I cancel it.

Students who require MMR vaccine AND Varicella (chickenpox) vaccine will be immunized with the combination MMRV vaccine that provides protection against measles, mumps, rubella and varicella.

PARENT / GUARDIAN / REPRESENTATIVE USE ONLY

Measles, Mumps and Rubella (MMR)

If your child has received 2 doses of MMR vaccine after 1 year of age, they **DO NOT** need this vaccine. If they have received one or more doses of MMR vaccine, please give date(s):

VACCINE Dose #1	YYYY / MM / DD
VACCINE Dose #2	YYYY / MM / DD

I want my child immunized: ☐ **Yes** ☐ **No**

Signature	Date (YYYY / MM / DD)

PARENT / GUARDIAN / REPRESENTATIVE USE ONLY

Varicella (Chickenpox)

If your child has received 2 doses of varicella vaccine after 1 year of age, they **DO NOT** need this vaccine. If they have received one or more doses of varicella vaccine, please give date(s):

VACCINE Dose #1	YYYY / MM / DD
VACCINE Dose #2	YYYY / MM / DD

Has your child ever had chickenpox disease or shingles?
☐ **No** ☐ **Yes, at** ______ **years of age****
****If yes, was your child living in B.C. and seen by a health care provider?
☐ **No** ☐ **Yes**

I want my child immunized: ☐ **Yes** ☐ **No**

Signature	Date (YYYY / MM / DD)

PUBLIC HEALTH USE ONLY – TELEPHONE CONSENT

TELEPHONE CONSENT OBTAINED FROM	FOR	PHONE NUMBER CALLED	DATE (YYYY / MM / DD)
RELATIONSHIP TO CHILD	**MMR Vaccine** ☐ **YES** ☐ **NO** **MMRV Vaccine** ☐ **YES** ☐ **NO**	NURSE SIGNATURE	TIME ☐ AM ☐ PM

PUBLIC HEALTH USE ONLY – CHILD'S IMMUNIZATION RECORD

		Date YYYY / MM / DD	SITE	LOT #	NURSE SIGNATURE
☐ **MMR Vaccine**	1ST DOSE		☐ LA ☐ RA		
	2ND DOSE		☐ LA ☐ RA		
☐ **MMRV Vaccine**	1ST DOSE		☐ LA ☐ RA		
	2ND DOSE		☐ LA ☐ RA		

NURSE'S NOTES

Personal information collected on this form will be used by the health authority to update the student's immunization record. The information will be used and disclosed in accordance with the *Freedom of Information and Protection of Privacy Act*. Summary statistical information may be reported to the Ministry of Health. If you have any questions about the collection and use of this personal information, contact your local public health nurse. You may be contacted to request your participation in the evaluation of this school immunization program.