

PLEASE COMPLETE SECTIONS 1 AND 2

SECTION 1 : STUDENT'S PERSONAL INFORMATION

SCHOOL			GRADE	TEACHER (HOMEROOM)	
LAST NAME			FIRST NAME	GOES BY	
DATE OF BIRTH (YYYY/MM/DD)	BIRTH GENDER <input type="checkbox"/> M <input type="checkbox"/> F	IDENTIFIES AS <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X	MEDICARE #	NAME OF PARENT / LEGAL GUARDIAN	
DAYTIME PHONE (work or home)		OTHER DAYTIME PHONE		PARENT'S / LEGAL GUARDIAN'S EMAIL	
A L L E R G I C	DOES YOUR CHILD HAVE ALLERGIES? <input type="checkbox"/> NO <input type="checkbox"/> YES*				
	*IF YES, TO WHAT AND WHAT TYPE OF REACTION :				
	DOES YOUR CHILD HAVE A HEALTH PROBLEM? <input type="checkbox"/> NO <input type="checkbox"/> YES*				
	*PLEASE EXPLAIN :				
	DOES YOUR CHILD TAKE ANY MEDICATIONS? <input type="checkbox"/> NO <input type="checkbox"/> YES*				
	*PLEASE LIST :				

SECTION 2 : PARENT / LEGAL GUARDIAN CONSENT

Check YES or NO, sign, and date.

Your signature will confirm the following :

- I have read the information I was given on the Meningococcal (Men-C-ACYW-135) vaccine.
- I understand the benefits and possible reaction(s) for the vaccine and the risk of not getting vaccinated.

If you have any questions, please call your local Public Health office.

Meningococcal (Men-C-ACYW-135) Vaccine – 1 dose		
<input type="checkbox"/> YES, vaccinate my child. <input type="checkbox"/> NO, do not vaccinate my child. If no, please specify :		
Signature of parent/legal guardian ➔	Date (YYYY/MM/DD)	

FOR PUBLIC HEALTH NURSE USE ONLY

SECTION 3 : TO BE COMPLETED BY PUBLIC HEALTH NURSE

Meningococcal (Men-C-ACYW-135)	Lot #	Site	Route	Dosage	Date (YYYY/MM/DD)	Time	Signature
<input type="checkbox"/> NIMENRIX <input type="checkbox"/> MENACTRA <input type="checkbox"/> MENVEO		<input type="checkbox"/> Right arm <input type="checkbox"/> Left arm	IM	0.5 mL			

SECTION 4 : PERSONAL IMMUNIZATION RECORD

This section is to be completed by the Public Health Nurse. This immunization record will be given to your child after their immunization. Please keep this record with your child's personal health files.

Meningococcal (Men-C-ACYW-135) Vaccine			
STUDENT'S NAME			
DOB (YYYY / MM / DD)		MEDICARE #	
NAME OF VACCINE : <input type="checkbox"/> NIMENRIX <input type="checkbox"/> MENACTRA <input type="checkbox"/> MENVEO		DATE (YYYY / MM / DD)	
		TIME	
NURSE'S SIGNATURE			

The personal health information provided here is collected and used by New Brunswick Public Health within the Public Health Information System (PHIS) for the purposes of delivering immunizations, and to prevent, investigate and manage outbreaks of vaccine preventable disease. Your personal health information is processed in accordance with the *Personal Health Information Privacy and Access Act*.