Centre intégré
de santé
et de services sociaux
de la Montérégie-Ouest
Québec

MOCLI60110

Dossier : _____

Nom, prénom : _____

Date de naissance : _____ ☐ F ☐ M
aaaa/mm/jj

NAM : _____ Exp. _____
aaaa/mm

Nom, prénom de la mère : _____

Installation : _____

CONSENT TO SCHOOL VACCINATION 14-16 YEARS OLD

If you are 14 and over, you do not need a parent's consent to receive a vaccine.

IDENTIFICATION

Address: _____ City: _____

Postal code:_____Phone no.: ( )_____-_____Other: ( )_____- _____

Name of school: _____

MEDICAL INFORMATION *Please answer all the questions.*	**Yes**	**No**
1. Have you noticed any changes in your health recently?	☐	☐
2. Have you ever had a severe reaction or a severe allergic reaction after receiving a vaccine that required emergency medical care? • If yes, what caused it or what vaccine did you have: _____	☐	☐
3. Do you have blood coagulation problems?	☐	☐
4. Do you have an immune deficiency?	☐	☐
5. Have you received a blood transfusion or an injection of immunoglobulins or a vaccine in the last 11 months? If yes, specify: _____	☐	☐
6. Did you ever have chickenpox after the age of 1 year? • If not, did you receive the chickenpox vaccine?	☐ ☐	☐ ☐
7. Are you pregnant?	☐	☐

	CONSENT Based on the nurse's assessment, the following vaccines are recommended:	**1st vaccination**		**2nd vaccination** (as needed) Date: yyyy/mm/dd	
		Accept	**Refuse**	**Accept**	**Refuse**
☐	Meningococcus A, C, W, and Y	☐	☐	☐	☐
☐	Diphtheria and tetanus	☐	☐	☐	☐
☐	Diphtheria, pertussis (whooping cough), tetanus and poliomyelitis	☐	☐	☐	☐
☐	Measles, mumps and rubella	☐	☐	☐	☐
☐	Hepatitis ☐ Hepatitis A ☐ Hepatitis B	☐	☐	☐	☐
☐	Human papilloma virus (HPV)	☐	☐	☐	☐
☐	Chickenpox	☐	☐	☐	☐
☐	Other:: _____	☐	☐	☐	☐

Signature:_____**Date:** _____**Time**: _____
*For users under age 14, the signature of a parent or guardian is required yyyy/mm/dd hh:mm

Signature:_____**Date**:_____**Time**: _____
Nurse Permit no. yyyy/mm/dd hh:mm

Nom, prénom : #Dossier :

RESERVED FOR USE BY THE NURSE AND THE VACCINATOR			# SI-PMI:
RESERVED FOR USE BY THE VACCINATOR Vaccines administered	**Lot no.**	**Brand name**	**Site**
☐ Men-C-ACWY 0.5 ml IM		☐ Menactra ☐ Nimenrix ☐ Menveo	☐ Left arm ☐ Right arm
☐ dT 0.5 ml IM		☐ Td Adsorbed	☐ Left arm ☐ Right arm
☐ dcaT-VPI 0.5 ml IM		☐ Boostrix-Polio ☐ Adacel-Polio	
☐ MMR (*contents of single-dose SC format*)		☐ MMRII ☐ Priorix	☐ Left arm ☐ Right arm
☐ MMR-Var (*contents of single-dose SC format*)		☐ Priorix-Tetra ☐ ProQuad	
☐ HA 0.5 ml IM		☐ Avaxim ☐ Havrix ☐Vaqta	☐ Left arm ☐ Right arm
☐ HB 0.5 ml IM		☐ Recombivax ☐ Engerix-B	
☐ HAHB 0.5 ml IM		☐ Twinrix Junior	
☐ HPV-9 0.5 ml IM		☐ Gardasil 9	☐ Left arm ☐ Right arm
☐ Var (*contents of single-dose SC format*)		☐ Varivax III ☐ Varilrix	☐ Left arm ☐ Right arm
☐ Other: _____			☐ Left arm ☐ Right arm
Notes: _____ ☐ SI-PMI entered ☐ Exemption entered (Var)			
Signature: _____ Vaccinator	Permit no.	**Date**: _____ yyyy/mm/dd	**Time**: _____ hh:mm

PRE-VACCINATION ASSESSMENT BY NURSE 2nd dose:	**Yes**	**No**	**If yes, specify**
Allergic reaction since the last vaccine?	☐	☐	
Change in student's health condition since completing the "Medical Information" section?	☐	☐	
Vaccines received since the last school vaccine?	☐	☐	

Signature: _____ **Date**: _____ **Time**: _____
Nurse Permit no. yyyy/mm/dd hh:mm

RESERVED FOR USE BY THE VACCINATOR Vaccines administered	**Lot no.**	**Brand name**	**Site**
☐ Men-C-ACWY 0.5 ml IM		☐ Menactra ☐ Nimenrix ☐ Menveo	☐ Left arm ☐ Right arm
☐ dT 0.5 ml IM		☐ Td Adsorbed	☐ Left arm ☐ Right arm
☐ MMR (*contents of single-dose SC format*)		☐ MMRII ☐ Priorix	☐ Left arm ☐ Right arm
☐ MMR-Var (*contents of single-dose SC format*)		☐ Priorix-Tetra ☐ ProQuad	
☐ HPV-9 0.5 ml IM		☐ Gardasil 9	☐ Left arm ☐ Right arm
☐ HA 0.5 ml IM		☐ Avaxim ☐ Havrix ☐Vaqta	☐ Left arm ☐ Right arm
☐ HB 0.5 ml IM		☐Recombivax ☐ Engerix-B	
☐ HAHB 0.5 ml IM		☐ Twinrix Junior	
☐ Var (*contents of single-dose SC format*)		☐ Varivax ☐ Varilrix	☐ Left arm ☐ Right arm
☐ Other: _____			☐ Left arm ☐ Right arm
☐ Other: _____			☐ Left arm ☐ Right arm
			☐ ☐
Notes: _____ ☐ SI-PMI entered			
Signature: _____ Vaccinator	Permit no.	**Date**: _____ yyyy/mm/dd	**Time**: _____ hh:mm