

CONSENT FORM GRADE 9 VACCINATION 2026-2027 COHORT

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

- 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:		E-mail address:		
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 aiguë, modérée, ou grave, avec ou sans fièvre?					T° C (le cas échéant) :		☐ Oui ☐ Non		☐ Non
A reçu un vaccin ou fait un test TCT dans les 4 dernières semaines?							☐ Oui ☐ Non		☐ Non
Est enceinte ?							☐ Oui ☐ Non		☐ Non
A une contre-indication à une vaccination? Si oui, préciser.							☐ Oui ☐ Non		☐ Non
Information / Bénéfices et effets secondaires expliqués?							☐ Oui ☐ Non		☐ Non
Attente x 15 min demandé ?							☐ Oui ☐ Non		☐ Non
Commentaires :									
DÉCISION DE L'INFIRMIÈRE									
Administrarer les vaccins suivants :									
dT/dcaT	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) ☐ Boostrix / Adacel (dcaT) ☐ 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 / Recombivax (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/Priorix-Tetra (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	☐ à jour ☐ _____ doses
Saisie SI-PMI (Initiale)									