Men-C-ACYW-135 VACCINE

MENACTRA® For meningococcal disease

Vaccine Consent Form

Last Name: _____

First Name: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Contact Phone Number: _____

Address: _____

Town/City: _____ Postal Code: _____

School: _____

I have read or had explained to me information about the Men-C-ACYW-135 vaccine. I have had the chance to ask questions, which were answered to my satisfaction.

_____ _____

Signature Date

☐ No, I do not wish for my child to receive this vaccination.

For more information, please contact a member of the Vaccine Preventable Disease Team by calling the Haldimand-Norfolk Health Unit at 519-426-6170 or 905-318-6623.

OFFICE USE ONLY

☐ Panorama Nurses Signature: _____

Vaccine	Dose	Route	Site	Date	Time	Lot #

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Simcoe:
P.O. Box 247,
12 Gilbertson Dr.,
Simcoe, ON N3Y 4L1
519-426-6170 or 905.318.6623

Caledonia:
282 Argyle St. S,
Caledonia, ON N3W 1K7
905.318.6623