THE REGIONAL MUNICIPALITY OF HALTON
Tel: 905-825-6000 TTY: 905-827-9833 Fax: 905-465-3403

Halton REGION

STATEMENT OF IMMUNIZATION FOR SCHOOL ENTRY

The Immunization of School Pupils Act, 1990, requires your child be immunized against six diseases: measles, mumps, rubella (German Measles), diphtheria, tetanus and polio. This requirement can only be removed if you object to immunization for medical, conscience or religious reasons and you have completed the necessary exemption form obtained from the Health Department.

Please complete this form and return it to the secretary immediately.

School: _____ **Entry Date:** _____

Name: _____ / _____ **Sex: F___ M___**
Last First

OHIP # _____

Birth Date: _____ _____ _____ **Previous school:** _____
year month day

Address: _____
Street City/Town Postal Code

Parent/Guardian: _____ **Home #**_____ **Work#**_____

Please fill in dates of all immunizations since birth:

* Required for school attendance							Recommended vaccines						
Vaccine / **Dates Given (yy/mm/dd)**	**Diphtheria ***	**Tetanus ***	**Polio (IPV or OPV)***	**Measles ***	**Mumps ***	**Rubella ***	**Hib (haemophilus influenza type B**	**Pertussis (Whooping Cough)**	**Pneumococcal (Synflorix™ / Prevnar®)**	**Meningococcal (NeisVac-C® / Menjugate® or Menactra®)**	**Hepatitis B**	**Varicella (chickenpox)**	**Other**

Personal health information on this form is collected pursuant to section 11 the *Immunization School Pupils Act*, R.S.O. 1990, c. I. 1 and will be used by Halton Region's Medical Officer of Health to maintain an immunization record for this child and to take appropriate action to prevent vaccine preventable diseases. Questions about this collection can be directed to nurses within the Immunization Services Program, Halton Region Health Department, 1151 Bronte Road, Oakville, ON, L6M 3L1, 905-825-6000 or toll free at 1-866-442-5866.

Please complete reverse side

HEALTH INFORMATION

Is your child healthy? Yes ___ No ___ If no please describe your child's health concerns:

_____

_____

_____

Does your child have an allergy? Yes ___ No ___ If yes, to what is he/she allergic ?

_____

Please describe the type of reaction._____

_____

Has your child had hepatitis? Yes ___ No ___ If yes describe the illness_____

_____

Does your child have a vision problem: Yes ___ No ___

Does your child wear glasses: Yes ___ No ___ Contact Lens: Yes ___ No ___

Does your child have a hearing problem: Yes ___ No ___

Does your child wear a hearing aid: Yes ___ No ___

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