Region of Peel
Working for you

Assessment Questions for Students with Special Needs

Dear Parent/ Legal Guardian,

Please read and complete this assessment form and **attach it to the immunization consent form** provided. Both forms must be signed and returned in order for your child to be immunized. By answering the following questions, you will help the Registered Nurse decide if it is safe for your child to be immunized. Please read consent(s) carefully before signing.

Last Name (Individual to be immunized)	**First Name** (Individual to be immunized)	Date of Birth (YYYY/MM/DD) ____ / ____ / ____

School: _____

1. Does your child have any allergies to food, medication, or any vaccine?..... ☐ Yes ☐ No
   If yes, please list: _____

2. Does your child have any medical problems?..... ☐ Yes ☐ No
   If yes, please explain: _____

3. Please list any medication(s) that your child is presently taking:
   _____

4. Is there a chance your daughter could be pregnant?..... ☐ Yes ☐ No

5. Has your child had any reactions to vaccines in the past? …….. ☐ Yes ☐ No
   If yes, please describe: _____

6. Does your child get upset when receiving a needle? ……. ☐ Yes ☐ No
   If yes, please describe: _____

7. Are you planning to be present when your child gets his/ her needle?..... ☐ Yes ☐ No
   If not, how can we make your child more comfortable? _____

If your child's condition changes after completing this form please call **Peel Public Health** at **905-799-7700.**

Please notify your child's teacher if your child is not feeling well enough to receive the vaccine on the day of the immunization clinic.

If your child has been on antibiotics and does not have a fever or a severe illness, it is safe for him/ her to have the vaccine.

Please have your child wear a shirt with loose-fitting short sleeves on the day of the clinic.

Should you have any questions or concerns, call **Peel Public Health** at **905-799-7700** to speak with an Immunization Nurse.

Printed Name: (Individual giving Information) _____ _____
Last Name **First Name**

Relationship to individual being immunized ☐ **Parent/Step-Parent** ☐ **Grandparent** ☐ **Legal Guardian**
☐ **Foster Parent** ☐ **Sibling (over 18)** ☐ **CAS worker**

Signature: _____ _____/ ____/ ____
Date **(YYYY/MM/DD)**

Home Phone Number ☐☐☐ - ☐☐☐ - ☐☐☐☐

Daytime Phone Number ☐☐☐ - ☐☐☐ - ☐☐☐☐

Notice with respect to the Collection of Personal Information:
This information is being collected pursuant to the Health Protection and Promotion Act R.S.O. 1990 c.H.7 and will be retained, used, disclosed and disposed of in accordance with all applicable municipal, federal, and provincial laws and regulations governing the collection, retention, use, disclosure and disposal of personal information including the Municipal Freedom of Information and Protection of Privacy Act R.S.O. 1990 c. M. 56, the Personal Health Information Protection Act 2004 S.O. 2004 c.3. This information will be used by Peel Public Health for the purposes of the administration and evaluation of the Vaccine Preventable Diseases Program. Any questions regarding this collection may be directed to the Medical Officer of Health, Peel Public Health, P.O. Box 667, RPO Streetsville, Mississauga, ON, L5M 2C2. 905-799-7700.