"Give BC Kids the MCV4 Shot".

Vaccination is the ONLY Protection!

www.meningitisbc.org

April 19, 2016

Dear Parents and 2016 Graduating Students:

MeningitisBC.org is pleased to announce that we will be sponsoring Meningitis Vaccine Clinics for two (2) types of meningitis vaccines: BEXSERO® (4CMenB – protects against Meningitis B-strain) and MENVEO™ (Protects against meningitis strains A, C, W-135 & Y) for 2016 graduating students on the following dates and place:

PLACE: *SAANICH FAIR GROUNDS – GALLERY ROOM*

MENINGITIS VACCINE CLINIC DATES:	Day	Date	Time
1st Dose of (4CMenB) - BEXSERO®	Friday,	May 6th	1:30 p.m. – 5:00 p.m.
MCV4 (A, C, W-135 & Y) - MENVEO™	Wednesday,	May 18th	1:30p.m. – 5:00 p.m.
2nd Dose of (4CMenB) - BEXSERO®	Friday,	Jun. 10th	1:30 p.m. – 5:00 p.m.

ALL COMPLETED VACCINE CONSENT FORMS MUST BE RETURNED TO THE SCHOOL OFFICE BY: MONDAY, APRIL 25, 2016

London Drugs Store #46 – Colwood Corners Shopping Centre have graciously volunteered to administer the 4CMenB vaccine BEXSERO® and the MCV4 vaccine MENVEO™.

The vaccines cost $120.00 per dose and ***must be paid*** *for prior to the vaccination clinic day*. The total cost for all vaccines is $360.00, but you do not need to pay for them all at once, just the vaccine for that particular clinic date. Please check with your extended health care plans as some do cover the cost, like Manulife.

Parents/Students that cannot pay the vaccine costs ***directly*** at *London Drugs Store #46 – Colwood Corners Shopping Centre, 1907 Sooke Road, Victoria, B.C.* for the meningitis vaccine clinics, you can pay the vaccine costs through our website: www.meningitisbc.org using a credit card via Pay Pal, for a particular meningitis vaccination clinic date, location and meningitis vaccine type. Please be aware that there will be an addition cost of $3.90 cents per $120.00 vaccine cost to process the Pay Pal transaction.

Payments made through Pay Pal will have individual sales receipts produced by the pharmacy as per vaccine clinic schedule for your records, and these will be disbursed to the said student on the vaccine clinic day.

It is our hope that you will take this opportunity to protect your child from the five (5) most common strains of meningitis that cause invasive meningitis disease world-wide, by completing the attached *Consent Forms* for the multicomponent meningococcal B vaccine (4CMenB) BEXSERO® (*note*, two (2) completed consent forms are required for the Men-B vaccine) and the MCV4 vaccine MENVEO™.

PLEASE TAKE A MOMENT TO READ THE INFORMATION THAT IS ON THE BACK OF THIS LETTER, AS WE VERY MUCH WANT YOU TO BE EDUCATED ABOUT THIS SERIOUS DISEASE. ALSO, SPEAK WITH YOU PERSONAL HEALTH CARE PROVIDER ABOUT THESE MENINGITIS VACCINES.

Yours truly,

Janet Munro
MeningitisBC.org – Founder/Chairperson

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Who Are We?

MeningitisBC.org is a non-profit society founded by BC parents who have lost our children to a strain (Y-strain) of meningitis, a disease that could have been prevented by a simple vaccination. BC children are only vaccinated against one strain of meningitis – MenC, (in Grade 6). However, a quadrivalent meningococcal conjugate vaccine called MCV4 was and is available to purchase, and has been implemented in the public immunization programs in 9 other provinces and territories in Canada. To learn more about our children's personal stories, please visit our website: www.meningitisbc.org.

What is Meningitis?

Meningococcal meningitis, the most common form of meningococcal disease, is caused by the Neisseria meningitidis bacterium. It causes inflammation of the lining of the brain and spinal cord and/or widespread infection of the blood and major organs. There are many strains of meningitis, but world-wide there are five (5) strains responsible for almost all of the meningococcal disease cases. These are A, B, C, W-135 and Y. Health Canada approved BEXSERO® 4CMenB) vaccine in late December 2014. The Meningitis B-strain has caused meningitis outbreaks throughout the United States at high schools, colleges and universities. Between 2008 and 2015, Meningitis B-strain has caused 108 deaths in United States.

Signs and Symptoms?

Meningitis mimics the flu and is often misdiagnosed. Early symptoms begin mildly and can occur suddenly and include: high fever, severe headache, vomiting, stiff neck. The infection progresses rapidly, and if left untreated, a previously healthy young adolescent or adult will die within 24 – 48 hours. The symptoms may appear any time between 1 to ten days after exposure, but usually within 3 to 4 days.

Even with appropriate medical attention, 10% of people who contract meningococcal disease die and another 20% of survivors suffer from lifelong disabilities such as loss of limbs, organ failure, deafness, blindness, and/or neurological damage.

Who is at Risk?

The highest incidence of disease is seen during our typical "Flu Season", winter and spring. Most commonly affected are infants under one year and children aged one to four followed by the 15-24 years age group. The median age affected by the Y-Strain in Canada is 49.

Health professionals say that this disease is rare; about 1 in 100,000 contract the disease, but 1 in 5 healthy adolescents or young adults carry the bacteria in their nose and throat at any point in time without showing any signs of the disease. The carrier state can persist for several months.

Why Vaccinate?

Many daily and social activities that adolescents and young adults are involved in puts them at a greater risk of spreading or contracting meningococcal disease, such as: Living in close quarters, such as college/university dormitories; Being in crowded situation for prolonged periods of time; Staying out late and having irregular sleeping patterns, which weakens the immune system; besides playing sports, mouth guards, musical instruments, sharing water bottles, utensils, food, drinks, cosmetics, cigarettes, kissing, coughing and sneezing. The bacterium is spread through droplets of secretions from the nose and throat.

A "booster dose" of MCV4 vaccine is recommended for adolescents aged 16-18 years to ensure that circulating antibodies are present during the peak years (15-27 years) for invasive meningococcal disease. Vaccinating this largest carrier group will prevent and protect against spread of the disease.

Information about Meningitis Vaccines and Possible vaccine reactions – via Link to HealthLink BC

http://www.healthlinkbc.ca/healthfiles/hfile23b.stm - HealthLinkBC Meningococcal Quadrivalent Vaccines

http://www.healthlinkbc.ca/healthfiles/hfile23c.stm - HealthLinkBC Meningococcal B (Men-B) Vaccine

https://www.youtube.com/watch?v=FuhFp22YbpM - Youtube Video: The Fastest Hour

Consent for the administration of vaccines/medications

First and Last Name: _____ Age: _____ Birth Date: _____

Address: _____ Telephone: _____

Doctor's name and telephone: _____

PHN (Personal Health Number): _____ Weight (if a minor): _____

Vaccine/Medication Requested: _____

Note: Injections will not be provided to any children younger than 5 years of age. These individuals will be referred back to their physicians. The parent or legal guardian must be present before an injection will be provided to any child age 5 to 18 years.

Name and relationship of person requesting injection for a minor (5 to 18 years):

_____

Your health and safety is a priority. The following questions are to ensure that you do not have any contraindications and so we can provide appropriate counselling. Please let us know if you have any concerns or questions.

Please answer the questions below:

Allergies:

- Have you ever had a serious reaction to any medication in the past? Yes ☐ No ☐
  - o If yes, describe: _____
- Are you allergic to the following:
  - o Thimerosal, formaldehyde or any other preservative? Yes ☐ No ☐
  - o Latex? Yes ☐ No ☐
- Are you allergic to antibiotics (including; Neomycin, Kanamycin, Gentamycin, Streptomycin)? Yes ☐ No ☐
  - o If yes, list: _____
- Do you have any food allergies, including to eggs or egg products? Yes ☐ No ☐
  - o If yes, list: _____
- List any other known allergies: _____

Illness:

- Do you presently have a fever, infection, or any acute illness? Yes ☐ No ☐
- Do you have any of the following:
  - o An active or unstable disorder of the nervous system? Yes ☐ No ☐
  - o An autoimmune condition? Yes ☐ No ☐
  - o A bleeding disorder? Yes ☐ No ☐
  - o Have you had Guillain-Barré? Yes ☐ No ☐
- List any current medical conditions: _____

Medication:

- Do you take any of the following medications:
  - o Immunosuppressant such as a Corticosteroid or Prednisone? Yes ☐ No ☐
  - o Anticoagulant such as Warfarin or ASA? Yes ☐ No ☐
  - o Beta-blocker? Yes ☐ No ☐
- Have you received any blood products or vaccines in the past 30 days? Yes ☐ No ☐
- List any medication that you currently take: _____

Pregnancy/Breastfeeding:

- If you are a woman, are you pregnant or think you may be? Yes ☐ No ☐
- If you are a woman, are you currently breastfeeding? Yes ☐ No ☐

Other:

- Are you a resident of Canada? Yes ☐ No ☐
- If you are older than 50 years of age, have you had the shingles vaccine? Yes ☐ No ☐
- Have you ever fainted after receiving an injection? Yes ☐ No ☐
- List any other problems: _____

Consent for the administration of vaccines/medications

Initial (only if applicable): _____ I supplied the vaccine/medication to the Injection Pharmacist. I am solely responsible for the manner in which the vaccine/medication was stored and handled before providing it to the Injection Pharmacist. I understand that if the vaccine/medication was not properly stored or handled, its stability and effectiveness may be negatively affected for which the Injection Pharmacist and London Drugs bear no responsibility.

POSSIBLE COMMON SIDE EFFECTS/ADVERSE REACTIONS: I understand the explanation provided to me by the pharmacist regarding any possible common side effects or adverse reactions.

Any prolonged or unusual reaction needs to be reported to a doctor. Allergic/anaphylactic responses are rare and are likely a consequence of hypersensitivity to some component of the medication. This reaction is characterized by hives, swelling of the tongue and lips, and/or difficulty breathing. **This is an emergency and requires *immediate* treatment.**

WAIVER: By signing this Consent form, I waive any claim, demand, action or proceeding for any liability, expense, loss or damage of any nature that I (or anyone claiming on my behalf) may have against London Drugs, its directors, officers and employees as well as the administering nurse or pharmacist and medical advisor (collectively the "Releasees") due to any side effect and any personal injury, illness, or death that I experience or suffer directly or indirectly as a result of receiving this vaccine/medication.

Without limiting the intent and effect of the above waiver, I irrevocably submit to the exclusive jurisdiction of the courts of the province in which this injection was administered if I initiate against the Releasees any claim, demand, action or proceeding relating to this injection or this document (collectively, "Claims") and agree that the resolution of all Claims will be governed by and construed in accordance with the laws of the province in which this injection was administered and, to the extent applicable, the laws of Canada.

CONSENT: I have read and understand the risks and benefits of receiving this vaccine/medication. I acknowledge that I have had an opportunity to ask questions and that they were answered to my satisfaction prior to receiving the injection.

I consent to the collection, use and disclosure of the personal information included in this form by and to London Drugs and its nurses, pharmacists, pharmacy employees and medical advisors for the purposes of screening, providing health care services and to assess the need for further medical treatment or response and, where appropriate for reasons of health, safety or medical necessity, other health care professionals, including physicians and hospitals. I understand my family doctor and regulatory or regional health authorities may be notified of this injection of vaccine/medication unless I expressly request that this not be done.

I AGREE TO REMAIN IN THE CLINIC AREA OF LONDON DRUGS FOR A MINIMUM OF 15 MINUTES AFTER I RECEIVE THE INJECTION AND TO IMMEDIATELY NOTIFY THE PHARMACIST OF ANY ADVERSE REACTION. **This is so that I may be observed for the rare occurrence of an anaphylactic reaction, which is an emergency and requires *immediate medical treatment*.** I solely bear the risk of all consequences, including personal injury, illness or death, if I refuse or fail to remain in the clinic area for the time required by the Injection Pharmacist.

Having read, understood and agreed with all the terms of this document, I hereby agree to same by signing where indicated below.

SIGNATURE: _____ **DATE:** _____

Print Name: _____

If the individual to be injected is a minor (age 5 to 18):

I, _____, hereby represent and warrant that I am the legal guardian of the minor to be injected and have the authority to enter into this consent on behalf of the minor.

SIGNATURE (of parent or legal guardian): _____ DATE: _____

Print Name: _____ WITNESS: _____

The administering pharmacist or nurse may refuse to administer the vaccine to any person in his/her sole discretion.

RECORD OF ADMINISTRATION TO BE COMPLETED BY THE INJECTION PHARMACIST

Date: _____ Time: _____ Injection Site: _____ Right: _____ Left: _____

Dose: _____ Route: Subcutaneous: _____ Intramuscular: _____ Intradermal: _____ Intranasal: _____ Oral: _____

Manufacturer: _____ Brand: _____ Expiry Date: _____

Lot Number: _____ Comments: _____

Signature of the Injection Pharmacist providing Injection: _____

LONDON DRUGS pharmacy

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Consent for the administration of vaccines/medications

First and Last Name: _____ Age: _____ Birth Date: _____

Address: _____ Telephone: _____

Doctor's name and telephone: _____

PHN (Personal Health Number): _____ Weight (if a minor): _____

Vaccine/Medication Requested: _____

Note: Injections will not be provided to any children younger than 5 years of age. These individuals will be referred back to their physicians. The parent or legal guardian must be present before an injection will be provided to any child age 5 to 18 years.

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Please answer the questions below:

Allergies:

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  - o If yes, describe: _____
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  - o Anticoagulant such as Warfarin or ASA? Yes ☐ No ☐
  - o Beta-blocker? Yes ☐ No ☐
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- List any medication that you currently take: _____

Pregnancy/Breastfeeding:

- If you are a woman, are you pregnant or think you may be? Yes ☐ No ☐
- If you are a woman, are you currently breastfeeding? Yes ☐ No ☐

Other:

- Are you a resident of Canada? Yes ☐ No ☐
- If you are older than 50 years of age, have you had the shingles vaccine? Yes ☐ No ☐
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Print Name: _____ WITNESS: _____

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Lot Number: _____ Comments: _____

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LONDON DRUGS pharmacy

TRUSTED SINCE 1945

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Waiver and Release Form

I grant ***Meningitisbc.org*** :

- Copyright and/or use of my photographic images and/or video and/or testimonials in various forms of media, including printed or multi-media materials, to be used by or for ***Meningitisbc.org*** to assist in publicity, promotion, awareness, marketing and/or educational purposes
- The permission to identify me by name, school and such identifiers as class year, graduation date and hometown (if applicable)

I hereby realize and accept that I am participating on a voluntary basis and will not receive financial compensation from the photographer/videographer/interviewer, from ***Meningitisbc.org*** or any firm publishing and/or distributing the finished product.

-Children under 18 years old must have a parent or legal guardian sign this waiver on their behalf. ***Are you signing this waiver as a parent or legal guardian****? If yes, check here:* ☐

Please indicate name of child: _____

I understand and agree to this release.

NAME _____
(please print)

EMAIL _____

PHONE _____

SIGNATURE _____

WITNESS _____
(please print)

EMAIL _____

PHONE _____

SIGNATURE _____

DATE _____

DO YOU THINK THAT THE MCV4 & 4CMENB MENINGITIS VACCINES SHOULD BE PART OF THE BC PUBLIC IMMUNIZATION PROGRAM? (THIS TESTIMONIAL MAY BE USED IN PROMOTIONAL MATERIALS)

Respecting Your Privacy

MeningitisBC.org, is committed to respecting your privacy. The personal contact information you provide here will not be published without your permission. It may be used to contact you to discuss matters pertaining to the use and reproduction of your photo and it may be shared with other MeningitisBC.org Board of Directors for this purpose. Any personal information you provide is managed according to the British Columbia Freedom of Information and Protection of Privacy Act (FOIPPA).