

Human Papillomavirus (HPV) Immunisation



VACCINATION CONSENT FORM



Please complete this form and return to school as soon as possible, even if you do **not** wish for your child to have the vaccine.

Information about the vaccine will be shared with Child Health and your child's GP surgery.

Child's full name: (first name and surname)		Date of Birth:
Home address: Postcode:		Gender: Male / Female Emergency contact number for parent/guardian:
Email:		Religion:
NHS number (if known):		Ethnicity of child:
GP name and address:		GP telephone number:
School:		Year Group/Class:

Further information on the vaccine can be found at:

<http://www.nhs.uk/Conditions/vaccinations/Pages/hpv-human-papillomavirus-vaccine.aspx>

PARENT / GUARDIAN: Please read the leaflet supplied then sign ONE box only.

***THE PERSON WITH PARENTAL RESPONSIBILITY MUST SIGN THIS FORM – for more information, please go to:**
<https://www.gov.uk/parental-rights-responsibilities/who-has-parental-responsibility>

Please note: young people under the age of 16 can give or refuse consent if considered competent to do so by nursing staff.

<p>I have read the leaflet supplied.</p> <p>YES, I WANT my child to receive the full course of two HPV vaccinations:</p> <p>Parent / Guardian name:</p> <p>Signature:</p> <p>Relationship to child:</p> <p>Date:</p>	<p>I have read the leaflet supplied.</p> <p>NO, I DO NOT WANT my child to receive the full course of two HPV vaccinations:</p> <p>Parent / Guardian name:</p> <p>Signature:</p> <p>Relationship to child:</p> <p>Date:</p> <p>Reason for refusal:</p>
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Parent / Guardian to complete this section:

Parent / Guardian PLEASE ANSWER THE QUESTIONS BELOW:	PARENT / GUARDIAN (please circle, if YES please give details *)	NURSE USE ONLY	
		1 st HPV	2 nd HPV
Has your child got any allergies?	Yes / No	Y / N	Y / N
Does your child have a bleeding disorder?	Yes / No	Y / N	Y / N
Has your child had 2 doses of the MMR vaccine?	Yes / No		

*If you answered **yes** to any questions please give details here:

or email the form to consent.newham@nhs.net

FOR OFFICE USE ONLY

For completion by immunisation nurses

First HPV Vaccination		
Batch:		Expiry:
Date/time given		
Site administered	LA	RA
Route:	IM	SC
Given by: (Name / Signature)		

Second HPV Vaccination		
Batch		Expiry:
Date/time given		
Site administered	LA	RA
Route:	IM	SC
Given by: (Name / Signature)		

HAS THIS VACCINE BEEN GIVEN WITH VERBAL CONSENT

Yes / No

Name of Parent / Guardian giving consent: _____

Has consent been given by the young person using Gillick competence?

No / Yes – *form attached*

Nurse Comments:

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