

Vaccination Consent Form – Human papillomavirus (HPV)

The HPV vaccine that protects against several types of cancer is being offered to your child at school. To get the best protection, two doses are required. Please discuss with your son or daughter and complete in black ink and return to your child's school before the vaccine is due. If you have any questions, please contact the school immunisation nurse.

Child's details	
Child's Surname:	Date of Birth:
First Name:	NHS Number (if known):
Gender: (circle as appropriate) Male Female	School and class:
Home Address:	GP name and address:
Daytime contact telephone number: Parent/Guardian Mobile:	Ethnicity:

Important information about this immunisation	
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Does your child have any long-standing medical conditions or taking any regular medication? If so, please give details below:	No	Yes*
Does your child have any known allergies? If so, please give details below:	No	Yes*
Has your child ever had a serious allergic reaction to any immunisation that has required hospital treatment? If so, please give details below:	No	Yes*
If your child has already had this immunisation at your own GP Practice, please indicate here and return the form in the usual way.		

Consent for 2 doses of HPV immunisation (Dose 2 to be given a minimum of 6 months after dose 1) Please complete <i>one</i> section only

YES, I consent for my child to receive the full course of two HPV vaccinations.

Signature of parent/guardian (with parental responsibility):

.....Date:.....

Relationship to child:

NO, I DO NOT consent for my child to receive the HPV vaccine.

Signature of parent/guardian (with parental responsibility):

.....Date:.....

Relationship to child:

FOR USE OF INTRAHEALTH STAFF ONLY

If the consent form has not been signed by a parent/guardian please assess young person's ability to self-consent.

Can the young person?	Yes	No
Understand what immunisation is being given?		
Understand what disease/infection the immunisation is protecting them from?		
Understand what risks of not having the vaccine are?		
Understand what side effects the immunisation can cause?		
Hold on to that information?		
Use the information to make an informed decision?		
Written information regarding immunisation given?		

Encourage child to make decision with parent/guardian. If health care staff are unable to contact parent/guardian and young person is deemed as Gillick competent then the child can self-consent to the vaccination.

YES I CONSENT TO RECEIVING THE HPV IMMUNISATION

Childs Name:

Childs Signature

Nurses Name:

Nurses Signature:

Date:

Nurses Checklist	Yes	No
Details on form correct?		
Well today?		
Taking any medications?		
Any reactions to previous immunisations?		
Any allergies?		
Any possibility of pregnancy?		
Information leaflet given?		

To be completed by nurse.

Date/Time of HPV Vaccine	Injection Site	Name of Vaccine Batch Number Expiry Date	Immuniser (print name and sign)	Where vaccine administered (e.g GP,School)
<i>Dose 1:</i>				
<i>Dose 2:</i>				

Date	IntraHealth Staff Comments	Signature / Print Name