## **Human Papillomavirus (HPV) VACCINATION CONSENT FORM**





Date of Birth:



## Thank you for completing this form. Please discuss this

Child's **full** legal name (first name and surname) and preferred name if different:

with your child and return to the school within one week of receipt.

The Q&A sheet that accompanies this form tells you about the vaccination, why it is being offered and the virus it protects against. For further information please visit www.nhs.uk (search for HPV).

PLEASE ALSO COMPLETE YOUR CHILD'S NAME AND DATE OF BIRTH OVERLEAF												
Home address:	Daytime contact telephone number/mobile for parent/guardian:											
Postcode:	NHS Number:		Ethnicity:									
School			Year group/Class:									
GP name and address:												
				YES	NO							
Does your daughter have any allergies?				123	110							
Is your daughter taking any medication?												
Does your daughter have any medical conditions?												
If you have answered yes to any of the above or there is any other information you wish to share with us, please give details.  Consent for HPV Vaccination Course (Please complete one box only)												
YES I CONSENT for my child to receive the vaccination course.	<b>NO I DO NOT CONSENT</b> for my child to receive the full HPV vaccination course.											
By giving consent you agree to the statements (if not, please dele	Please tick reason for declining below and return form to school.											
I have read the enclosed parental letter & Heaflet	☐ Do not feel that the vaccine is necessary											
☐ Due to a previous allergic reaction to the vaccine  I understand that the information provided will be shared with my GP to updates my child's health record.  ☐ Due to a previous allergic reaction to the vaccine  ☐ Other (Please state) use separate sheet if necessary												
Full Name of person with Parental Respons	Full Name of person with Parental Responsibility:											
Signature of person with Parental Responsi	Signature of person with Parental Responsibility:											
Date:	Date:											
☐ I confirm I have parental responsibility for the above named child												

Name:												
DOB:			NHS	No:								
FOR OFFICE USE ONLY												
Part	Date of vaccination	Site of in (please	njection e circle)	Batch nu expiry o		Immunis (please print d		Where administered (if not school)				
First		<b>L</b> arm	R arm									
Second		<b>L</b> arm	R arm									
Information given as per PGD (Please tick) Part 1 Part 2												
Use below <b>ONLY</b> for girls <u>starting</u> HPV vaccination course over the age of 15 years, requiring 3 doses.												
	V ONL FIOI GIRS Sta	arung mev v		course over t	ne age of	15 years, requir	ing 3 dose					
Third		L arm	R arm									
Informati	on given as per P	GD (Please	tick) Pa	rt 3 🗆								
IMMUNISATION COMMUNICATION RECORD												
DATE/TII	ME						NAME, T	TITLE & SIGNATURE				
							<u> </u>					