

Human Papillomavirus (HPV) Vaccination Consent Form

The HPV vaccine that protects against cervical cancer is being offered to your daughter at her school. The leaflet that accompanies this form tells you and your daughter about the HPV vaccine. To get the best protection **it is important that she receives both injections** over the next twelve months. Please discuss this with your daughter then complete the form and return it to the school before the vaccination is due to be given. Your GP's surgery will be sent details of vaccinations given so that this information can be put onto the health record. If you have more questions please contact the School Nurse via email at ECCH.Schoolmms@nhs.net or other Health Professional or go to www.nhs.uk/Conditions/vaccinations/Pages/hpv-human-papillomavirus-vaccine.aspx for further information.

Girl's full name (please include previous surname)	Date of birth:
Home address:	Daytime contact telephone number for parent/carer:
	Parent/carer mobile number if different from above:
School:	
GP Surgery:	
Please state known allergies and medical conditions:	
<i>Any side effects following the HPV vaccination should be reported to the School Nurse or your GP</i>	

Parent/Guardian consent for two HPV vaccinations (*Please complete one box only*)

I want my daughter to receive the full course of three HPV vaccinations and confirm I have legal responsibility for her	I do not want my daughter to have the HPV vaccine and confirm I have legal responsibility for her
Name	Name
Signature Parent/guardian	Signature Parent/guardian
Date	Date

If, after discussion, you and your daughter decide that you do **not** want her to have the vaccine, it would be helpful if you would give the reason for this below (*and return the form to school*).

Reason for not wanting the vaccine:

Thank you for completing this form. Please return it to the school as soon as possible.

***FOR OFFICE USE ONLY**

Date of HPV vaccination		Site of Injection <i>(please circle)</i>		Batch Number/ Expiry date	Immuniser <i>(please print)</i>	Where administered <i>(School, college etc)</i>
First		L arm	R arm			
Second		L arm	R arm			

CONSENT SIGNED: YES/NO

LEAFLET READ: YES/NO

ATTENDED ASSEMBLY: YES/NO

UNDERSTANDING: YES/NO

1ST IMMUNISATION

COMMENTS

- ARE YOU WELL TODAY?
 HAVE YOU EATEN TODAY?
 DO YOU HAVE ANY ALLERGIES?
 DO YOU HAVE ANY MEDICAL CONDITIONS?
 DO YOU TAKE ANY MEDICINES/TABLETS?
 HAVE YOU HAD ANY INJECTIONS IN LAST 4 WEEKS?
 HAVE YOU EVER FAINTED?
 ANY POSSIBILITY OF PREGNANCY?
 HAS AFTERCARE ADVICE BEEN GIVEN?

DATE TIME SIGNATURE

2ND IMMUNISATION

COMMENTS

- ARE YOU WELL TODAY?
 HOW DID YOU FEEL AFTER YOUR INJECTION?
 HAVE YOU EATEN TODAY?
 ANY CHANGES TO YOUR HEALTH?
 HAVE YOU STARTED TAKING ANY NEW MEDICINES?
 ANY NEW ALLERGIES?
 ANY POSSIBILITY OF PREGNANCY?
 HAS AFTERCARE ADVICE BEEN GIVEN?

DATE TIME SIGNATURE