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| **School Immunisation Team**  **Human Papilloma Virus Vaccination Consent Form** |

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| **1** | Child’s Surname *(and any previous Surname*): | Child’s Forename(s): | Date of Birth: |

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| **2** | **Would you like your child to receive the HPV vaccination (please tick)?** | |
| ***YES, I CONSENT TO THE FULL COURSE:***  (please complete sections 3 to 5 and return form to school) | | ***NO, I DON’T CONSENT TO THE FULL COURSE:***  (please return form to school) |

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| **3** | Address & Postcode *(please write previous address overleaf if less than 3 years)* : | Phone number of parent/guardian: |
| Email of parent/guardian: |
| Ethnicity: |
| GP Surgery: : | NHS Number: |
| School Name: | Year Group: |

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| **4** | Has your child ever had a severe allergic reaction to any previous vaccines or medication? | **Yes \*** | **No** |
| Does your child take any prescribed medication? | **Yes \*** | **No** |
| Does your child have any long-standing medical conditions? | **Yes \*** | **No** |
| \* If you answered yes to any of the above, please give details: | | |

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| **5** | Signature of parent/guardian (with parental responsibility): | |
| Relationship to child: | Date: |

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| **OFFICE USE ONLY** | | | | | | | |
| Has the parent consented (in 2) and signed (in 5)? | | | | | | Yes | No |
| HPV Vaccine, 0.5ml as per PGD | Date: | Time: | Site of IM injection  (Please circle) | | Batch number & Expiry date: | Immuniser: | Location: |
| 1st |  |  | **L** | **R** |  |  |  |
| 2nd |  |  | **L** | **R** |  |  |  |

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| 1st: Nurses’ Checklist | | 2nd: Nurses’ Checklist | | Nurses’ Comments: |
| Allergies |  | Allergies |  |
| Medication |  | Medication |  |
| Recent vaccines |  | Recent vaccines |  |
| Febrile illness |  | Febrile illness |  |
| Pregnancy |  | Pregnancy |  |