Shropshire Community Health **NHS**
NHS Trust

HUMAN PAPILLOMAVIRUS (HPV) VACCINATION CONSENT FORM

Name of proposed procedure: HPV VACCINATION - GARDASIL

Dear Parent/Guardian

Please complete the following details and return to school within one week.

Last name	**First name/s**	**Date of Birth**
Home address **Post Code**		**Daytime contact telephone number for parent/guardian**
NHS number (if known)		
School/College		**Year group/form**
GP name and address		

Consent for two HPV vaccinations *(Please complete **one** box only)*

I **want** my daughter to receive the full course of two HPV vaccinations, as the parent/guardian with parental responsibility I consent;	I **do <u>not</u> want** my daughter to have the HPV vaccine, as the parent/guardian with parental responsibility I do not consent;
Signature:	**Signature:**
Print Name:	**Print Name:**
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 reasons for this on the back of the form and return to the school. Please turn over to complete further information. **Any side effects following the HPV vaccination should be reported to the Immunisation Team, School Nurse or your GP please see attached information letter.** Information about the vaccinations will be put on your daughter's health records, including records at her GP's surgery and those held by the NHS. Thank you for completing and returning this form.

Statement of Health Professional; I have explained the procedure to the patient. Information leaflets have been sent to the patient/parent/guardian. In particular, I have explained:

The intended benefits; to offer protection against cervical cancer and genital warts. I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient. The following leaflet has been supplied; **Arm against cervical cancer or 123 Against HPV.**

FOR OFFICIAL USE ONLY

Vaccine: GARDASIL **Dose: 0.5ml x 2 IM**	Site of Injection (please circle)		Batch number/ expiry date	Immuniser (legible signature/print)	Date Vaccine Given	Time
First HPV vaccination	**L** arm	**R** arm				
Second HPV vaccination	**L** arm	**R** arm				

Please turn over and complete the reverse

lgd

This is a once only vaccination course, if your daughter has already received 2/3 doses of HPV vaccine, either Cervarix or Gardasil she does not require any further injections. If you are unsure of her immunisation details please contact the Child Health Department, phone: 01743 450800 and ask for the Immunisation clerks and we will contact the appropriate services to obtain her immunisation details.

If your child has already received this vaccine, please tell us here with the date/s:
Has your child received any vaccinations in the last 12 months? If yes please give details and date:
Has your child ever had an adverse reaction to a vaccine? If yes please give details:
Does your child have any general health problems? Please give details:
Is your child taking any regular medication? Please give details:
Does your child have any allergies? Please give details:
If your child has an on-going medical condition or communication difficulties that you would like to tell us about to assist the immunising nurses, please give details:

For Office Use Only: Comment Sheet for Vaccinations & Immunisations

Patient Name:	**NHS Number:**

Date & Time	**Comments**	**Signature**

Please turn over and complete the reverse