Human papillomavirus (HPV)

Vaccination consent form

The HPV vaccine, which protects against cervical cancer, is being offered to your daughter at school. The leaflet that accompanies this form tells you about the HPV vaccine. To get the best protection, it is important that your daughter receives all three injections over the next six months. Please discuss this with your daughter, then complete this 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 on your health record. If you have more questions, please contact the school nurse or Immunisation Specialist Nurse or go to www.immunisation.nhs.uk/hpv for further information.

*** *required information* (PLEASE PRINT)**

***Girl's full name (first name and surname):**	***Date of Birth:**
***Home address:**	***Contact mobile telephone number for parent/carer:**
NHS number *(if known):*	**Ethnicity:**
***School:**	***Year group/class:**
***GP name and address:**	

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

I **want my daughter** to receive the full course of three HPV vaccinations	I **do not want my daughter** to have the HPV vaccine
Parent/Guardian Name	Parent/Guardian Name
Signature Parent/Guardian	Signature Parent/Guardian
Date	Date

If, after discussion, you decide that you do **not** want to have the vaccine, it would be helpful if you would give the reasons for this on the back of this form in the space provided *(and return to the school).*

Any side effects following the HPV vaccination should be reported to the school nurse or your GP

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

* FOR OFFICE USE ONLY. STUDENTS, PLEASE DO NOT WRITE BELOW THIS LINE!!

Date of HPV vaccination		Site of injection *(please circle)*		Batch number/ expiry date	Immuniser *(please print)*	Where administered *(School, college, GP etc)*
First		**L** arm	**R** arm			
Second		**L** arm	**R** arm			
Third		**L** arm	**R** arm			

Reasons for Refusal:

_____

_____

_____

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Client Assessment

	Dose 1	Dose 2	Dose 3
Is the client well today?			
Is the client taking any medication?			
Previous medical history (particularly bleeding disorders or immunodeficiency disorders)			
Has the client experienced any previous side affects to medication?			
Any possibility that the client could be pregnant?			
Is the client allergic to anything?			
When did the client last have an injection?			
Name and Designation			