arm against cancer

Human papillomavirus (HPV)

Vaccination consent form

NHS

'he HPV vaccine that protects against several types of cancer is being offered to your child at school. To get the)est protection, two doses are required. The second injection will be usually offered six to 12 months after the first. 'he school will let you know when the second dose will be given. The leaflet 'Your guide to the HPV vaccination' ent with this form includes more information about the vaccine. Please discuss this with your son or daughter, then :omplete this form and return it to the school before the vaccination is due. Information about the vaccinations will)e put on your child's health records. If you have any questions, please contact the school immunisation nurse.

Child's full name (first name and surname):	Date of birth:
Home address:	Daytime contact telephone number for parent/carer:
NHS number (if known):	Ethnicity:
School:	Year group/class:
GP name and address:	Gender (circle as appropriate): **Male** **Female**

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

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

after discussion, you and your child decide that you do not want them to have the vaccine, it would be helpful you would give the reasons for this on the back of this form (and return to the school).

atch up sessions for missed vaccinations are offered regularly at school. Please be advised GP)rgeries are not commissioned to carry out the HPV Vaccination. If you have any queries, please ontact the school immunisation nursing team or liaise with your 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.

)FFICE USE ONLY						
)ate of HPV vaccination		Site of injection (please circle)		Batch number/ expiry date	Immuniser (please print)	Where administered (school, college, GP etc)
:irst		L arm	R arm			
		L arm	R arm			

If you and your child would like to have the HPV immunisation then:

PLEASE ANSWER THE FOLLOWING QUESTIONS	*YES	NO
1. Do they have any specific allergies?	☐	☐
2. Have they ever had a severe reaction to previous immunisations?	☐	☐
3. Are they seeing the GP or a hospital Doctor for any reason?	☐	☐
4. Are they receiving any regular treatment or medication?	☐	☐
5. Have they had any injections in the last 3 months? (*if yes when)	☐	☐

* If YES to any of the above please specify:

If after discussion, you and your child decide that you DO NOT want them to have the vaccine, it would be helpful if you would give the answers for this in the box below and (return to school)

Reason for non-consent:

School Nurse comments: