



## Human Papillomavirus (HPV) Immunisation VACCINATION CONSENT FORM



Please complete this form and return to school as soon as possible, even if you do not wish for your child to have the vaccine.

*Information about the vaccine will be shared with Child Health and your child's GP surgery.*

Child's full name: (first name and surname)		Date of Birth:
Home address:  Postcode:		Gender: Male / Female Emergency contact number for parent/guardian:
Email:		Religion:
NHS number (if known):		Ethnicity of child:
GP name and address:		GP telephone number:
School:		Year Group/Class:

Further information on the vaccine can be found at:

<http://www.nhs.uk/Conditions/vaccinations/Pages/hpv-human-papillomavirus-vaccine.aspx>

**PARENT / GUARDIAN: Please read the information supplied then sign ONE box only.**

\*THE PERSON WITH PARENTAL RESPONSIBILITY MUST SIGN THIS FORM – for more information, please go to:  
<https://www.gov.uk/parental-rights-responsibilities/who-has-parental-responsibility>

**Please note:** young people under the age of 16 can give or refuse consent if considered competent to do so by nursing staff.

<p style="text-align: center;">I have read the leaflet supplied.</p> <p><b>YES, I WANT</b> my child to receive the full course of two HPV vaccinations:</p> <p>Parent / Guardian name:.....</p> <p>Signature:.....</p> <p>Relationship to child:.....</p> <p>Date:.....</p>	<p style="text-align: center;">I have read the leaflet supplied.</p> <p><b>NO, I DO NOT WANT</b> my child to receive the full course of two HPV vaccinations:</p> <p>Parent / Guardian name:.....</p> <p>Signature:.....</p> <p>Relationship to child:.....</p> <p>Date:.....</p>
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**Parent / Guardian to complete this section:**

Parent / Guardian PLEASE ANSWER THE QUESTIONS BELOW:	PARENT / GUARDIAN <i>(please circle, if YES please give details *)</i>	NURSE USE ONLY  1 <sup>st</sup> HPV	NURSE USE ONLY  2 <sup>nd</sup> HPV
Has your child got any allergies?	Yes / No	Y / N	Y / N
Does your child have a bleeding disorder?	Yes / No	Y / N	Y / N
Has your child had <b>2 doses</b> of the MMR vaccine?	Yes / No		

\*If you answered **yes** to any questions please give details here:

**FOR OFFICE USE ONLY**

*For completion by immunisation nurses*

First HPV Vaccination		
Batch:		Expiry:
Date/time given		
Site administered	LA	RA
Route:	IM	SC
Given by: (Name / Signature)		

Second HPV Vaccination		
Batch		Expiry:
Date/time given		
Site administered	LA	RA
Route:	IM	SC
Given by: (Name / Signature)		

HAS THIS VACCINE BEEN GIVEN WITH VERBAL CONSENT

Yes / No

Name of Parent / Guardian giving consent: \_\_\_\_\_

Has consent been given by the young person using Gillick competence?

No / Yes – *form attached*

Nurse Comments:
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