Children & Young People's Health Services

PLEASE COMPLETE IN BLACK INK AND RETURN TO SCHOOL AS SOON AS POSSIBLE. PLEASE ENSURE THAT IT IS SIGNED BY SOMEONE WITH LEGAL PARENTAL RESPONSIBILITY

NHS

School Immunisation Team

Human Papilloma Virus Vaccination Consent Form

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

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)

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:

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:		

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

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**			

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