Human papillomavirus (HPV)

Vaccination consent form

The HPV (Human Papillomavirus) vaccine helps to protect against various cancers (Cervical, Head and Neck, Penile, Anal). It is being offered to your child at their **school.** Please read the accompanying letter for more information about this programme. To get the best protection, it is important that they have both injections over a period of about twelve months. Please discuss this with your child, then complete this form and return it to the school before the first 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 child's health record.

PLEASE COMPLETE IN BLOCK CAPITALS USING A BLACK PEN

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:

Consent for both HPV vaccinations *(Please complete **one** section only)*

☐ **I want** my child to receive the full course of two HPV vaccinations.		**Only complete this section if you DO NOT want your child to have the HPV vaccinations**
☐ **I confirm** I have answered the health questions on the back of this form		☐ **I do not want** my child to have the HPV vaccinations.
Name (Please print your name)		Name (Please print your name)
Signature Parent/Guardian		Signature Parent/Guardian
Date		Date

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 your child's school as soon as possible

THIS SECTION FOR SCHOOL NURSE USE ONLY

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

Please answer the health questions on the back of this form

Human papillomavirus (HPV)

Vaccination consent form

If you want your child to receive the full course of two HPV vaccinations, please answer the following questions:

Has your child had an adverse reaction to an injection in the past? ☐ **Yes** ☐ **No**	If yes, please give details:
Does your child have a blood disorder? ☐ **Yes** ☐ **No**	If yes, please give details:
☐ I **confirm** I will contact the School Nurse if my child experiences any changes in their health history over the next six months or during the course of the vaccination period.	

If, after discussion, you and your child decide that you **do not** want them to have the vaccinations, it would be helpful if you would give the reasons for this here and return the completed form to school.