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: Gender: Male / Female
Home address: Postcode:		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 leaflet 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.

I have read the leaflet supplied. **YES, I WANT** my child to receive the full course of two HPV vaccinations: Parent / Guardian name: ..... Signature: ..... Relationship to child: ..... Date:	I have read the leaflet supplied. **NO, I DO NOT WANT** my child to receive the full course of two HPV vaccinations: Parent / Guardian name: ..... Signature: ..... Relationship to child: ..... Date: ..... Reason for refusal: .....

Parent / Guardian to complete this section:

Parent / Guardian PLEASE ANSWER THE QUESTIONS BELOW:	**PARENT / GUARDIAN** *(please circle, if YES please give details *)*	**NURSE USE ONLY** **1st HPV**	**NURSE USE ONLY** **2nd 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 **2 doses** of the MMR vaccine?	Yes / No		

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

Email the form to consent.walsall@nhs.net

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: