arm against cancer

NHS
Essex Partnership University
NHS Foundation Trust

Human papillomavirus (HPV)

Vaccination consent form

The HPV vaccine that protects against several types of cancer is being offered to your child at school. To get the best protection, two doses are required. The second injection will be usually offered six to 12 months after the first. The school will let you know when the second dose will be given. The leaflet 'Your guide to the HPV vaccination' sent with this form includes more information about the vaccine. Please discuss this with your son or daughter, then complete this form and return it to the school before the vaccination is due. Information about the vaccinations will be 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:	Gender (circle as appropriate): **Male Female**
Home address:	Daytime contact telephone number for parent/carer:	
NHS number (if known):	Consent to text (circle as appropriate): **Yes No**	
School: Year group/class:	GP name and address:	

Has your child received a previous HPV vaccine? If **YES** please give details:	**YES** ☐	**NO** ☐
Has your child had a **CONFIRMED ANAPHYLACTIC REACTION** to a previous dose of HPV vaccine or any other vaccine? If **YES** please give details:	**YES** ☐	**NO** ☐
KNOWN ALLERGIES/ MEDICAL CONDITIONS:		

Consent 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)*
Relationship to child:	Relationship to child:
Date	Date:

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 reasons for this on the back of this form (and return to the school).

Any side effects following the HPV vaccination should be reported to the immunisation team or your GP

Thank you for completing this form. Please return it to the school as soon as possible.

Triaged		FAO Nurse ◯	

FOR OFFICE USE ONLY

Additional information	HPV 1		Eligibility assessment ON DAY of vaccination	HPV 2	
	YES	NO	CRITERIA - ELIGIBILITY	YES	NO
			Aged 12 or over		
			Aged under 18 (1st dose only)		
			Has completed a full course of HPV vaccine		
			Confirmed anaphylactic reaction to a previous dose of HPV vaccine		
			Confirmed anaphylactic reaction to any component of the vaccine		
			Acute or febrile illness		
			Evolving neurological condition e.g. unstable epilepsy. (HPV can be given when condition is stable or resolved)		
			Possibility of pregnancy (if applicable)		
			Valid consent		

If any of the answers are in the shaded boxes DO NOT vaccinate. Refer to the PGD for appropriate action.

After vaccination advice

- Your arm may feel uncomfortable for a few days.
- If you have any unusual symptoms please report them to your GP as soon as possible.
- Please stay in the company of the others and on the school site for at least 30 minutes.

HPV 1st dose

Signature: ..... Date: .....

HPV 2nd dose

Signature: ..... Date: .....

Gardasil Vaccination HPV 1

Batch number: ..... Expiry date: .....

Date: ..... Time: .....

Site: Left arm / IM Right arm / IM Dose: 0.5mls

Vaccine Sticker Space

Venue where administered:

School ☐ Clinic ☐ .....

Advice on side effects provided? **YES** ☐ **NO** ☐

Accredited written management advice provided? **YES** ☐ **NO** ☐

Administered by:

Signature: ..... Date: .....

Name: ..... RN ☐

Gardasil Vaccination HPV 2

Batch number: ..... Expiry date: .....

Date: ..... Time: .....

Site: Left arm / IM Right arm / IM Dose: 0.5mls

Vaccine Sticker Space

Venue where administered:

School ☐ Clinic ☐ .....

Advice on side effects provided? **YES** ☐ **NO** ☐

Accredited written management advice provided? **YES** ☐ **NO** ☐

Administered by:

Signature: ..... Date: .....

Name: ..... RN ☐

Input 1st dose		Input 2nd dose		Final Scan	