Human Papilloma Virus (HPV) Consent Form

Please note young people under the age of 16 years may give or refuse consent if considered competent to do so by nursing staff.
All sections must be completed. Please return this form to your child's school within seven days

Further information can be obtained from the NHS website www.nhs.uk/hpv or www.medicines.org.uk/emc/medicine/19033/pil/gardasil or contact your school nurse or another health care professional.

Student Surname (BLOCK LETTERS)	Student Forenames	Ethnicity	Date of Birth
Daytime Contact Number Landline Mobile	Address (BLOCK LETTERS) **inc postcode**		
School	Family Doctor &Telephone Number		

Has your child suffered a reaction to any previous immunisations?	**YES / NO**
Does your child have an anaphylactic reaction to any substance?	**YES / NO**
Are they currently being treated for any medical conditions?	**YES / NO**
Has your child had any immunisations in the past 3 months?	**YES / NO**

If you have answered yes to any section please give details and include date.

Please tick appropriate box:-

- ☐ I consent to my child receiving the full course of two HPV vaccinations
- ☐ I do not want my child to be immunised

Signature of the parent /guardian_____ Date_____

Relationship to young person_____

For medical use only
Signature of child (for self-consent) _____Date_____
Fraser competency assessed by_____ Date_____

Date of HPV vaccination		Site of injection		Batch number + expiry date	Immuniser/Designation (PLEASE PRINT)	After care advice given
First		**Left arm**	**Right arm**			**YES / NO**
Second		**Left arm**	**Right arm**			**YES / NO**

This data must be transcribed on to RIO records in keeping with CSH Surrey record keeping policy

Date	Comments	Action Plan / Action Taken	Practitioner (Print name)	Entered on Rio Practitioner (Print name)