**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](http://www.nhs.uk/hpv) or [www.medicines.org.uk/emc/medicine/19033/pil/gardasil](http://www.medicines.org.uk/emc/medicine/19033/pil/gardasil) or contact your school nurse or another health care professional.

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| --- | --- | --- | --- | --- |
| Student Surname ( BLOCK LETTERS) | Student Forenames |  | Ethnicity  | Date of Birth |
| Daytime Contact NumberLandlineMobile  | 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**For medical use only**

Signature of child (for self-consent) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fraser competency assessed by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **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)** |
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**PGD NUMBER CSH/C&F 001 09/14** Expiry Date 09/17

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