Give or refuse consent for an HPV vaccination

Use BLOCK CAPITALS and a ‘tick’ or ‘x’ for boxes

Session

Date

Location

Child’s details

1 Child’s official name

The first and last name on their passport or birth certificate.
If their name has changed, tell us their current name.

2 Child also known as

Tell us if they use a different name in school

3 Child’s GP surgery

4 Child’s date of birth

DD MM YYYY

5 Child’s home address

Postcode

Your details

6 Your name

7 Relationship to the child

If you’re not the child’s parent or guardian, you must have parental responsibility to give consent for the vaccination.

8 Email address

9 Telephone number

A nurse might call you about your child’s vaccination

Consent

10 Do you agree to your child having the HPV vaccination?

- Yes, I agree
- No, I do not agree

11 If you do not agree, please tell us why

Health questions

12 **Does your child have any severe allergies?**

☐ Yes ☐ No

If you answered yes, give details

13 **Does your child have any medical conditions for which they receive treatment?**

☐ Yes ☐ No

If you answered yes, give details

14 **Has your child ever had a severe reaction to any medicines, including vaccines?**

☐ Yes ☐ No

If you answered yes, give details

15 **Does your child need extra support during vaccination sessions?**

For example, they're autistic, or extremely anxious

☐ Yes ☐ No

If you answered yes, give details

Your signature

16 **Signed** **Date**