

Give or refuse consent for an HPV vaccination

Date: Tuesday 6 June 2023

Location: Hele's Secondary School

Use BLOCK CAPITALS and a 'tick' or 'x' for boxes

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 <input type="text"/> <input type="text"/>	4 Child's date of birth DD MM YYYY <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
2 Child also known as Tell us if they use a different name in school <input type="text"/>	5 Child's home address <input type="text"/> <input type="text"/> <input type="text"/> Postcode <input type="text"/>
3 Child's GP surgery <input type="text"/>	

Your details

6	Your name	9	Telephone number
	<input type="text"/>		<input type="text"/>
7	Relationship to the child		A nurse might call you about your child's vaccination
	<input type="text"/>		
8	Email address		
	<input type="text"/>		

Consent

10 Do you agree to your child having both doses of the HPV vaccination?	11 If you do not agree, please tell us why
<input type="checkbox"/> Yes <input type="checkbox"/> No	

Health questions

12 Does your child have any severe allergies that have led to an anaphylactic reaction?

☐

Yes

☐

No

Give details if you answered yes

13 Does your child have any existing medical conditions?

☐

Yes

☐

No

Give details if you answered yes

14 Does your child take any regular medication?

☐

Yes

☐

No

Give details if you answered yes

15 Is there anything else you think we should know?

☐

Yes

☐

No

Give details if you answered yes

Your signature

16 Signed

Date DD MM YYYY