Give or refuse consent for the HPV vaccination

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

Session

Date	Location

Child’s details

1 Child’s official name

Give the name on your child’s birth certificate. If it’s changed, give the name held by your child’s GP.

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 a bleeding disorder?

☐ Yes ☐ No

If you answered yes, give details

14 Does your child take blood-thinning medicine (anticoagulants)?

For example, warfarin, or other medicine used to prevent blood clots

☐ Yes ☐ No

If you answered yes, give details

15 Does your child have a disease or treatment that severely affects their immune system?

Children with a severely weakened immune system will need 3 doses of the vaccine, over a 12-month period

☐ Yes ☐ No

If you answered yes, give details

16 Does your child have any other medical conditions we should know about?

☐ Yes ☐ No

If you answered yes, give details

17 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

18 Signed

Date