Children & Young People's Health Services NORFOLK

IF YOU CONSENT TO YOUR CHILD RECEIVING THE HPV VACCINE COURSE, PLEASE COMPLETE THIS FORM

NHS

School Immunisation Team

Human Papilloma Virus Vaccination Consent Form

Child's Surname *(and any previous Surname)*:	Child's Forename(s):	Date of Birth:

Address & Postcode *(please write previous address overleaf if less than 3 years)* :	Phone number of parent/guardian:
	Email of parent/guardian:
	Ethnicity:
GP Surgery: :	NHS Number:
School Name:	Year Group:

Important medical information

Has your child ever had a severe allergic reaction to any previous vaccines or medication?	**Yes*** ☐ **No** ☐
Does your child take any prescribed medication?	**Yes*** ☐ **No** ☐
Does your child have any long-standing medical conditions?	**Yes*** ☐ **No** ☐

* If you answered yes to any of the above, please give details:

Consent for my child to receive the HPV vaccination

YES, I CONSENT TO THE FULL COURSE:	1st
Signature of parent/guardian (with parental responsibility):	2nd

Relationship to child:	Date:

OFFICE USE ONLY

HPV Vaccine, 0.5ml as per PGD	Date:	Time:	Site of IM injection (Please circle)		Batch number & Expiry date:	Immuniser:	Location:
1st			**L**	**R**			
2nd			**L**	**R**			

1st: Nurses' Checklist		2nd: Nurses' Checklist		Nurses' Comments:
Allergies		Allergies		
Medication		Medication		
Recent vaccines		Recent vaccines		
Febrile illness		Febrile illness		
Pregnancy		Pregnancy		