

## Human Papilloma Virus (HPV) Vaccination Consent

Dear Sir/Madam,

**RE: HPV Vaccine**

Human Papilloma Virus (HPV) is the most common viral sexually transmitted infection which can progress to cancer. The HPV vaccine protects against HPV related diseases such as oral, throat and anal/genital cancer, as well as cervical cancer in girls. The vaccine is being offered to your child at school. The leaflet that accompanies this form tells you and your child about the HPV vaccine. To get the best protection, it is important that he/she receives both injections over the next 18 months. Please discuss this with your child, then complete this form and return it to the school within 7 days. If you have more questions, please contact the Immunisation Team on the number below or visit our website [immunisation.cht.nhs.uk](http://immunisation.cht.nhs.uk). For further information you can also visit [nhs.uk/conditions/vaccinations](http://nhs.uk/conditions/vaccinations) and scroll down for the HPV vaccine.

**Please note: As this immunisation is part of the school aged programme, your GP may refuse to administer this vaccination at your surgery.**

Yours sincerely  
 Calderdale Immunisation Team  
 Brighouse Health Centre  
 01484 728956

Childs Full Name ( <i>first name and surname</i> ):	Childs Date of Birth:
Home Address:	NHS Number (if known)
Daytime Contact Telephone Number for Parent/Carer:	Ethnicity:
School:	Year Group/Class:
GP Name and Address:	

**P.T.O**

## Consent for two HPV vaccinations

(Please complete **one** box only)

I **want** my child to receive the full course of two HPV vaccinations

Name (parent/guardian with parental responsibility)

.....

Signature.....

Date.....

I **do not want** my child to have the HPV vaccine

Name (parent/guardian with parental responsibility)

.....

Signature.....

Date.....

**If consent has been given to receive HPV immunisation please answer the following questions:**

Has your child any medical conditions?

Is your child taking any medication?

Does your child have any allergies including latex?

Has your child had a confirmed anaphylactic reaction to a previous vaccine?

**Thank you for completing this form. Please return it to the school as soon as possible.**

**OFFICE USE ONLY**

Date and time of HPV vaccination		Site of injection (please circle)		Batch number/ expiry date	Immuniser (please print)	Where administered (school, clinic, GP etc)
1 <sup>st</sup> dose		L arm	R arm			
2 <sup>nd</sup> dose		L arm	R arm			