

The HPV vaccine that protects against several types of cancer is being offered to your child at school. To get the best protection, two doses are required. The second injection will usually be offered six to 12 months after the first, but can be up to 3 years after the initial dose. The school will let you know when the second dose will be given. The leaflet 'Your guide to the HPV vaccination' sent with this form includes more information about the vaccine. Please discuss this with your son or daughter, then complete this form and **return it via email to the address given overleaf to the School Age Immunisation Service before the vaccination is due**. Information about the vaccinations will be put on your child's health records. If you have any questions, please contact the School Age Immunisation Team.

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| Child's full name (first name and surname): | Date of birth: |
| Home address: | Daytime contact telephone number for parent/carer: |
| NHS number (if known): | Ethnicity: |
| School: | Year group/class: |
| GP name and address: | Gender: |

Your child will receive their first dose of the HPV vaccine in the next few weeks, and will be invited for their second dose after 6 months.

Consent for two HPV vaccinations (Please complete **one** box only)

| | |
|---|---|
| <p>I want my child to receive the full course of two HPV vaccinations</p> <p>Name</p> <p>Signature Parent/Guardian</p> <p>Date</p> | <p>I do not want my child to have the HPV vaccine</p> <p>Name</p> <p>Signature Parent/Guardian</p> <p>Date</p> |
|---|---|

If, after discussion, you and your child decide that you do not want them to have the vaccine, it would be helpful if you would give the reasons for this on the back of this form (and return to the email address overleaf).

Any side effects following the HPV vaccination should be reported to the school nurse or your GP

PLEASE TURN OVER

1) **Has your child received any doses of the HPV vaccination previously?**

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If you don't know, please ask your GP surgery to check the child's GP record.

2) **Please provide details e.g. name of vaccine received, where, when, and number of doses**

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3) **Has your child ever had a severe (anaphylactic) reaction to any vaccine?**

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Anaphylaxis is an extreme and severe reaction to an allergen that may result in difficulty breathing and shock and requires immediate medical assistance.

If YES, please tell us which vaccine/s:

Vaccine/s:

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There are very few contraindications to this vaccine, which means that it is unlikely that your child cannot have it. If we require any further information from the answers you have given, you will be contacted by a nurse.

If there is any change to your child's health during the course of the two vaccinations you must ensure that the School Aged Immunisation Service are made aware. In this event, please contact the team on 01425 891162. Thank you.

If you do not want your child to have the vaccine please give your reasons here

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Thank you for completing this form. Please return it via email to: dhc.hpvconsent@nhs.net

OFFICE USE ONLY

| Date of HPV vaccination | | Site of injection (please circle) | | Batch number/ expiry date | Immuniser (please print) | Where administered (school, college, GP etc) |
|-------------------------|--|--------------------------------------|-------|------------------------------|-----------------------------|---|
| First | | L arm | R arm | | | |
| Second | | L arm | R arm | | | |