Human Papillomavirus Vaccine (HPV) Consent Form

Instructions:

1. Read the following information before completing the consent form
   - Dear Parent(s)/Guardian(s) and Grade 8 Student Letter
   - Fact Sheet on the Human Papillomavirus Vaccine (HPV)
2. If you want your daughter to receive the vaccine at the school clinic, **complete SECTION A, B and E.**
3. If your daughter has already received the HPV vaccine, **complete SECTION A and C.**
4. If your daughter has already received one or two doses of the series and you would like the series to be completed at the school clinic, **complete SECTION A, B, C and E.**
5. If you do not want the Porcupine Health Unit to administer the HPV vaccine, **complete SECTION D.**

SECTION A

Last Name:	First Name:	Date of Birth: (yy-mm-dd)	Sex: Male ☐ Female ☐
Home Address:	Town:	Home Telephone #:	
Mother's Name & Telephone Number at Work:	Father's Name & Telephone Number at Work:		
School Name:	Room #:		
Doctor:			

SECTION B

☐ **YES**, I consent to have the Porcupine Health Unit administer the Human Papillomavirus (HPV) vaccine to my daughter. I understand this will include up to 3 shots given within the next 12 to 24 months. I have read the HPV vaccine fact sheet. I understand the benefits, risks and possible side effects to my child from HPV vaccination. I understand I can withdraw my consent at any time by calling the Porcupine Health Unit nurse assigned to my child's school. If my child has a serious adverse reaction to the vaccine I will go to a physician immediately and call the Porcupine Health Unit.

Date:_____ Signature:_____
(yyyy-mm-dd) (Parent/ Legal Guardian)

or

SECTION C

☐ **MY DAUGHTER HAS ALREADY RECEIVED THE HPV VACCINE (i.e. Gardasil®)**

Please provide the dates below. Three shots are required for full protection. If your daughter has not received all three shots, indicate the dates of the vaccine received and complete SECTION A, B, and E of the consent form if you want the series to be completed by the Porcupine Health Unit staff.

Date of First Dose:_____ Date of Second Dose:_____ Date of Third Dose:_____

If your daughter has received 3 doses, no additional doses are required at this time.

Date:_____ Signature:_____
(yyyy-mm-dd) (Parent/ Legal Guardian)

or

SECTION D

☐ **NO,** I do not consent to have the Porcupine Health Unit administer the HPV vaccine to my daughter. I understand the possible consequences if she is not vaccinated with the HPV vaccine.

_____ _____
(Name of Daughter) (Date of Birth)

Date:_____ Signature:_____
(yyyy-mm-dd) (Parent/ Legal Guardian)

SECTION E

Health History	Circle your response		If "yes" briefly describe	Reviewed by nurse before each dose (Please check) 1	2	3
Did your teenager have a reaction to a vaccine in the past?	Yes	No				
Does your teenager have allergies to the following: • Aluminum, yeast or sodium chloride • Other:_____ **Note: There is no antibiotic, preservative, latex or thimerosal in this vaccine.**	Yes	No				
Does your teenager have any serious health problems? **ie: seizures, paralysis, history of fainting**	Yes	No				
Is your teenager taking any medication that may lower his/her immune system, such as cancer therapy?	Yes	No				
Is your teenager pregnant or is there a chance she could become pregnant during the following months?	Yes	No				

Personal health information on this form is collected by the Porcupine Health Unit for the Vaccine Preventable Disease Program. For information about the way we protect the confidentiality of personal health information, call us or visit Porcupine Health Unit's Privacy Statement at www.porcupinehu.on.ca.

FOR NURSE'S USE ONLY

Student's Last Name:	Student's First Name:	Date of Birth: yy-mm-dd

Date & Time Vaccine Given (yy-mm-dd)	Trade name of the product / Disease against which it protects	Dosage & Route	Site (circle)	Manufacturer	Lot # / Expiry Date (yy-mm)	Nurse's Signature & Title
Date of Dose # 1 :	Gardasil®	0.5 mL / IM	Left deltoid / Right deltoid	Merck Frosst Canada Ltd.		
Time :	Human Papillomavirus type 6,11,16 and 18					
Date of Dose # 2 :	Gardasil®	0.5 mL / IM	Left deltoid / Right deltoid	Merck Frosst Canada Ltd.		
Time :	Human Papillomavirus type 6,11,16 and 18					
Date of Dose # 3 :	Gardasil®	0.5 mL / IM	Left deltoid / Right deltoid	Merck Frosst Canada Ltd.		
Time :	Human Papillomavirus type 6,11,16 and 18					

Comments:

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