



Human Papillomavirus (HPV) Vaccine Consent Form (for Grade 8 females only)

Student's Name: (Last) _____ (First) _____

Birth date: (Year) _____ (Month) _____ (Day) _____

Ontario Health Card Number (if available): _____

School Name: _____ **Grade:** _____ **Class:** _____

Please print clearly and complete the appropriate section(s).

YES. I consent to have Toronto Public Health administer the Human Papillomavirus (HPV) vaccine to my daughter, _____ to complete her HPV vaccination series. This will include up to 3 shots given within the next 12 to 24 months. I have read the Toronto Public Health 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. If my child has a serious adverse reaction to the vaccine I will go to a physician immediately and call Toronto Public Health.

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

Daytime Telephone Number: (_____) _____

OR

MY DAUGHTER HAS ALREADY RECEIVED THE HPV VACCINE (e.g. Gardasil®)

Please provide the dates below. Three shots are required for full protection. If your daughter has not received all three shots, please sign the above consent form to ensure she is fully protected.

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.

OR

NO. I do not consent to have Toronto Public Health administer the HPV vaccine to my daughter _____. I understand the possible consequences if she is not vaccinated with the HPV vaccine.

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

Please call the Immunization Information Line at 416-392-1250 if your child receives the Human Papillomavirus (HPV) vaccine in the future from another health care provider or if you require further information.

FOR NURSE'S USE ONLY

Human Papillomavirus (HPV) Vaccine for Grade 8 Females

Grade 8 female : yes no

HPV vaccine required : yes no

Doses required: 1 2 3

NURSING ASSESSMENT QUESTIONS	DOSE ONE	DOSE TWO	DOSE THREE
1. Have you received needles for Human Papillomavirus (HPV) immunization before today?	<input type="checkbox"/> yes <input type="checkbox"/> no	Dose One Date Checked Adequate Spacing (≥30 days) <input type="checkbox"/> yes <input type="checkbox"/> no Initials _____	Dose Two Date Checked Adequate Spacing (≥90 days) <input type="checkbox"/> yes <input type="checkbox"/> no Initials _____
2. Have you ever had a reaction to any immunization in the past?	<input type="checkbox"/> yes <input type="checkbox"/> no		
3. Did you have a reaction to the first/second Human Papillomavirus (HPV) needle? Did you receive any Human Papillomavirus needle since your last dose?		<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no
4. Do you understand what the needle is for?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
5. Are you allergic to the following: i/ aluminum ii/ yeast iii/ sodium chloride iv/ other Note: there is NO antibiotic, preservative, latex or thimerosal in this vaccine.	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no _____
6. Are you sick today with anything more than a cold? Do you have a fever?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no
7. Do you have any serious health problems, i.e. seizures, paralysis, history of fainting? Are you taking any medication that may lower your immune system, such as cancer therapy?	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no Comments: _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no Comments: _____	<input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> yes <input type="checkbox"/> no Comments: _____
8. Do you think you might be pregnant?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Nursing Notes:	Vaccine: Gardasil® Dose: 0.5ml Lot # _____ R / L deltoid Route: <u>IM</u> Date: _____ Time: _____ Signature of Nurse [] Preloaded syringe [] Self Loaded [] Loaded by: _____	Vaccine: Gardasil® Dose: 0.5ml Lot # _____ R / L deltoid Route: <u>IM</u> Date: _____ Time: _____ Signature of Nurse [] Preloaded syringe [] Self Loaded [] Loaded by: _____	Vaccine: Gardasil® Dose: 0.5ml Lot # _____ R / L deltoid Route: <u>IM</u> Date: _____ Time: _____ Signature of Nurse [] Preloaded syringe [] Self Loaded [] Loaded by: _____