Central and North West London NHS
NHS Foundation Trust

HUMAN PAPILLOMA VIRUS
VACCINATION CONSENT FORM

PLEASE COMPLETE ALL THE BOXES BELOW INCLUDING GP DETAILS IN BLACK INK AND IN CAPITALS
THE FORM MUST BE SIGNED BY THE CHILD'S PARENTS OR GUARDIAN

MUST BE COMPLETED - GP PRACTICE NAME & ADDRESS:-

Child's Full Name (First Name & Surname):	**Date of Birth:**	**Male / Female**
Home Address: **Postcode:**		**Daytime contact telephone number:**
Email Address:	**NHS Number (if known):**	
Ethnicity (PTO):	**School:**	**Year Group/Class:**

Has your child had a previous Measles, Mumps & Rubella (MMR) injection? (Dates can be found in your child's Red Book)	Yes Date of MMR1: _____ MMR2: _____	No
Does your child have a serious illness or allergy? (If yes, please give details) Please attach a separate sheet for additional information, if required.	Yes Please give details: _____	No
Is your child taking any medicines or receiving any medical treatment? Please attach a separate sheet for additional information, if required	Yes Please give details: _____	No

We are required to share the immunisation information with your child's School Nurse Service. Information is shared strictly in a secure method to ensure that it is only seen by the staff who require it. **If you do not want this information shared place a tick in this box** ☐

CONSENT FOR 2 DOSES OF THE HPV VACCINATION (6 – 12 months apart)

I have read and understood the information provided regarding the HPV vaccination

YES	**NO**
I **DO CONSENT** for my child to receive:- • 2 doses of the HPV vaccination	I **DO NOT CONSENT** for my child to receive:- • HPV vaccine
Signature: (parent / guardian)	Signature: (parent / guardian)
Print Name: (parent / guardian)	Print Name: (parent / guardian)
Relationship to Child:	Relationship to Child:
Date:	Date:

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ETHNICITY CODES:

WHITE	**British Irish**	**A**		**BLACK OR BLACK BRITISH**	**Caribbean**	**M**
	Gypsy or Irish Traveller	**CL**			**African**	**N**
	Any other white background	**C**			**Any other Black background**	**P**
MIXED	**White and Black Caribbean**	**D**		**OTHER ETHNIC GROUP**	**Chinese**	**R**
	White and Black African	**E**			**Arab**	**SIL**
	White and Asian	**F**			**Any other ethnic background**	**S**
	Other mixed	**G**			**Not stated / Not disclosed**	**Z**
ASIAN OR BRITISH ASIAN	**Indian**	**H**				
	Pakistani	**J**				
	Bangladeshi	**K**				
	Any other Asian background	**L**				

***FOR OFFICE USE ONLY**

BCG scar present on arm (tick if yes): left: ☐ **right:** ☐

	Site of injection (please circle)		**Date Given**	**Batch Number & Expiry Date**	**Immuniser (Print)**	**Where administered**
HPV 1st dose	**L** arm	**R** arm				
HPV 2nd dose	**L** arm	**R** arm				