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| Human Papillomavirus (HPV)  Vaccination Consent Form – 2023/ 2024 | | | | | | | | | | | | | | | | | |
| **PLEASE RETURN COMPLETED CONSENT FORM TO SCHOOL BY MONDAY 30 JANUARY 2023** | | | | | | | | | | | | | | | | | |
| Your GP’s surgery will be sent details of vaccinations given so that this information can be put on your child’s health record. | | | | | | | | | | | | | | | | | |
| Child’s full name (BLOCK LETTERS *- ﬁrst name and surname)* | | | | | | | | | | | | | Date of Birth: | | | | |
| Home address: (BLOCK LETTERS) | | | | | | | | | | | | | Daytime contact telephone number for parent/carer: | | | | | |
|  | | | | | | | | | | | | |
|  | | | | Post Code: | | | |  | | | | |  | | | | |
| School: | | | | | | | | | | | Contact email: | | | | | | |
| GP name and surgery: | | | | | | | | | | | | | | | | | |
| Is your child receiving medical treatment or do they have a condition which increases their risk of bleeding or affect their ability to be given vaccines?  *(if yes, please give details overleaf)* | | | | | | | | | | | | | | | | Yes  No | |
| Consent for vaccination: | | | | | | | | | | | | | | | | | |
| * I confirm that I have read the product information leaflet for HPV Vaccine. * I understand that I am giving consent for the administration of 2 doses of HPV Vaccine over approximately 12 months. * I confirm by signing this form that I am authorised to give consent on behalf of the above-named student.   Please complete one box only | | | | | | | | | | | | | | | | | |
| **I want** the above-named child to receive the full course of 2 HPV vaccinations | | | | | | | | |  | I **do not want** the above-named child to have the HPV vaccine | | | | | | | |
| Name: (*print)*  Parent/Guardian | | | | | | | | | Name: (*print)*  Parent/Guardian | | | | | | | |
| Relationship to Child: | | | | | | | | | Relationship to Child: | | | | | | | |
| Signature: Date: | | | | | | | | | Signature: Date: | | | | | | | |
| 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 school).* | | | | | | | | | | | | | | | | | |
| **\* FOR 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  Dose | Is child well today? | | Yes | | | No | Does child meet criteria for PGD410? | | | | | | | Yes  No | | | **Initials:** |
|  | **Left** arm | | | **Right** arm | |  | | | | |  | | |  | | |
| Second Dose | Is child well today? | | Yes | | | No | Does child meet criteria for PGD410? | | | | | | | Yes  No | | | **Initials:** |
|  | **Left** arm | | | **Right** arm | |  | | | | |  | | |  | | |
| |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | **First:** | Trak: | Input: | Scan: | Initials: |  | **Second:** | Trak: | Input: | Scan: | Initials: |  |   The information you will provide on the consent form is required for the School Nursing Service for the purposes of administering immunisations in schools. This information will be processed in line with the Data Protection (Bailiwick of Guernsey) Law, 2017. For full details of our Fair Processing Notice and how we look after your data please visit: [www.gov.gg/hscprivacy](http://www.gov.gg/hscprivacy) If you don’t have access to the internet please contact us and a paper copy will be provided. | | | | | | | | | | | | | | | | | |

LADIES’ COLLEGE

**Year 8**