



Gardasil® Human Papillomavirus (HPV) Immunization Consent Form

The HPV Gardasil® vaccine is administered in 3 doses through a voluntary school based immunization program. Please read the attached HPV information and if further information is required, call 625-5971 or visit www.tbdhu.com

Please complete and return this form to your child's school.

Student's Last Name _____ First Name _____

Date of Birth (YY/MM/DD) _____ Age _____ Male Female

School _____ Grade _____

Parent/Guardian Contact Information (please print):

Name _____

Home () _____ Daytime Contact () _____

PLEASE CHECK ONE BOX ONLY AND SIGN BELOW:

Yes, please vaccinate my child with the Human Papillomavirus (HPV) vaccine.

I have read or had explained to me the attached information about the vaccine, benefits, side effects and risks of immunization. I am satisfied with the answers to my questions. Unless cancelled, this request is valid for the time needed to give all three doses of the vaccine.

If your child completes any doses of this vaccination from another health care provider, you need to report this information to the Health Unit.

No, I do not consent to have the HPV vaccine administered to my child.

X _____

Signature of parent/guardian

Date

If this vaccine has already been given, please provide the date(s).

Dose #1 date _____ Dose #2 date _____ Dose #3 date _____

NURSE USE ONLY

Vaccine: Gardasil® 0.5 mL IM

Dose #1

Date _____ Time _____ Deltoid Lt Rt Nurse Signature _____

Dose #2

Date _____ Time _____ Deltoid Lt Rt Nurse Signature _____

Dose #3

Date _____ Time _____ Deltoid Lt Rt Nurse Signature _____