Human Papillomavirus (HPV) Consent Form
& Vaccine Administration Record

Human Papillomavirus- Genital human papillomavirus (HPV) is the most common sexually transmitted infection in the United States; an estimated 6.2 million persons are newly infected every year. Although the majority of infections cause no symptoms and are self-limited, persistent genital HPV infection can cause cervical cancer in women and other types of anogenital cancers and genital warts in both men and women.

The Vaccine- Gardisil, the quadrivalent HPV vaccine, is administered intramuscularly as three separate 0.5-mL doses. The second dose should be administered 2 months after the first dose and the third dose 6 months after the first dose. The vaccine is available as a sterile suspension for injection in a single-dose vial or a prefilled syringe. The HPV vaccine is approved for females aged 9 to 26. It is most effective when given before the patient is sexually active.

Risk and Possible Side Effects- The HPV vaccine is safe and approved for use in females' ages 9 to 26 years. The HPV vaccine has similar side effects to most other vaccines. The most common side effects are:
Redness, tenderness, soreness, and swelling at the injection site, fever, nausea, dizziness, and headache.
Severe reactions, although very rare, can happen. These include: trouble with breathing, swelling of the face or mouth, fever over 39°C, hives or rashes. Seek medical attention immediately if you have any type of severe reaction to the vaccine.

Special Precautions- You should not get the HPV vaccine if you have already had all three HPV shots, have had a serious reaction to the HPV vaccine, have a yeast allergy/infection or are allergic to a vaccine component (e.g., aluminum, yeast, sodium chloride).

INFORMATION CONCERNING PERSON TO RECEIVE HPV VACCINE:

____
NAME (please print) DATE OF BIRTH AGE PHONE NUMBER

____
ADDRESS CITY STATE ZIP

DO YOU HAVE ALLERGIES TO: ☐ Aluminum ☐ Yeast ☐ Sodium Chloride ☐Other__________
ARE YOU PREGNANT? ☐ Yes ☐ No
DO YOU HAVE ANY SERIOUS HEALTH PROBLEMS (e.g., seizures, paralysis, history of fainting)? ☐ Yes ☐ No
ARE YOU ON ANY MEDICATION THAT MAY LOWER YOUR IMMUNE SYSTEM? ☐Yes ☐ No
HAVE YOU HAD A REACTION TO A PREVIOUS DOSE OF HPV VACCINE? ☐ Yes ☐ No

____
NAME & ADDRESS OF PRIMARY PHYSICIAN

CONSENT:
I have read the above information and have had an opportunity to ask questions. I understand the benefits and risks of the HPV vaccine as described. I request that the vaccine be given to me or to the person named below for whom I am authorized to sign.

____
SIGNATURE OF PERSON RECEIVING or AUTHORIZING VACCINE DATE

HPV Vaccination Information (*office use only*)

Gardisil Shot 1	**Gardisil Shot 2**	**Gardisil Shot 3**
Lot #:_________ Exp. / /	Lot #:________ Exp. / /	Lot #:_________ Exp. / /
Dose: 0.5mL Admin. Site: R L Arm Thigh	Dose: 0.5mL Admin. Site: R L Arm Thigh	Dose: 0.5mL Admin. Site: R L Arm Thigh
Amount Paid:_________________	Amount Paid:_________________	Amount Paid:_________________
Signature & Title of Vaccine Administrator:_______________________	Signature & Title of Vaccine Administrator:_______________________	Signature & Title of Vaccine Administrator:_______________________
Date Administered:_________________	Date Administered:_________________	Date Administered:_________________