FOR OFFICE USE ONLY

Name: Date of Birth: Client ID:

(If applicable) Class: School Roll Number:

Vaccination Consent Form for people receiving the HPV (Human papillomavirus) catch-up vaccine

This consent form needs to be completed for:

- **1 dose of HPV vaccine (for those with a healthy immune system)**
- **3 doses of HPV vaccine (for those with a weak immune system)**

This vaccine will be given during 2022 and 2023 only.

Please note only a parent or legal guardian can consent or refuse consent for students. Anyone 16 years or older are legally entitled to consent for themselves. Read more about consent on the HSE website https://bit.ly/ConsentU16.

COMPLETE THE FORM IN BLOCK CAPITALS USING A PEN.

Please complete this consent form and return it in the envelope provided before the vaccinations begin.

Privacy Statement: HSE staff are aware of their obligation under the Data Protection Acts, 1988-2018 (including GDPR). The information provided will be included in an Immunisation Database. The HSE will use this information to validate clients, monitor vaccination programmes and to provide health care. The data for HPV will be made available to CervicalCheck – The National Cervical Screening Programme for use in the context of its service.

Notes/Comments:

Personal Details

PART 1 Complete this part with the details of the person getting vaccinated **(PLEASE USE BLOCK CAPITALS)**

Forename: Middle Name:

Surname (Family Name): Otherwise known as:

Personal Public Services Number (PPSN):

(PPSN will be required to manage your immunisation record only)

Date of Birth: D D M M Y Y Y Y

Gender assigned at birth: Male ☐ Female ☐

Gender identity: Male (including Trans Male) ☐ Female (Including Trans Female) ☐

Mother's surname at birth:

(This information may be required to manage your immunisation)

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Name: ______ **Client ID:** ______

Address:

Eircode: County:

Address when they last had a vaccine:

Parent/Legal Guardian Forename and Surname if under 16 years of age:

Daytime Phone Number:

Mobile Phone Number:

Do you consent to receive texts about vaccine appointments? Yes ☐ No ☐

Ethnic or cultural background:

A. White *(Irish, Irish traveller, Roma, Ukrainian)* ☐ B. Black or Black Irish *(African, Any other Black background)* ☐

C. Asian or Asian Irish *(Chinese, any other Asian background)* ☐

D. other, including mixed background *(Arabic, any other write in description)* ☐

Description ______

Nationality: ______

Email:

Do you consent to receive emails about vaccine appointments? Yes ☐ No ☐

Class: Year:

School/College Name:

1. Have you previously received HPV vaccine? Yes ☐ No ☐
2. Have you had any serious illness in recent years? Yes ☐ No ☐

   Please detail ______
3. Are you currently taking medication? Yes ☐ No ☐

   Please detail ______
4. Have you ever had a severe reaction to **anything** including medication or vaccine (including anaphylaxis)? Yes ☐ No ☐

   Please detail ______
5. Do you have any illness or condition that increases your risk of bleeding? Yes ☐ No ☐

   Please detail ______
6. People with the conditions listed below need 3 doses of HPV vaccine because they have a weak immune system. If you think you/your child have any of these conditions please ask your Specialist/Consultant if you require 3 doses of HPV vaccine due to having a weak immune system, and tell the vaccination team when you attend your vaccination appointment.
   - Haematopoietic stem cell or solid organ transplant recipients
   - HIV infection
   - Malignant haematological disorders affecting the bone marrow or lymphatic systems, e.g., leukaemia, lymphomas, blood dyscrasias
   - Non-haematological malignant solid tumours
   - Primary immunodeficiency
   - Within two weeks of commencing, on or within three to six months of receiving significant immunosuppressive therapy

You can ask your Specialist/Consultant to visit **www.immunisation.ie** for further information to help with this discussion.

I have been advised by my treating Specialist/Consultant that I should have 3 doses of HPV vaccine due to having a weak immune system. Yes ☐ No ☐

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Name: ____ Date of Birth: ____ Client ID: ____

(If applicable) Class: ____ School Roll Number: ____

Choose Part 2 (**YES**) OR Part 3 (NO) for the HPV VACCINE

PART 2 Please tick the box to consent to receiving the HPV vaccine and sign to say **YES**

Yes, I consent to the vaccination of the above named with:

HPV ☐

- I have read and understand the accompanying vaccine information, including known side effects.
- I understand that HPV vaccine is not recommended during pregnancy.
- I understand that I am giving consent for the administration of 1 dose of HPV vaccine (complete this option if the person being vaccinated has a healthy immune system). ☐
- I understand that I am giving consent for the administration of 3 doses of HPV vaccine over 6 months (complete this option if the Specialist/Consultant treating the person being vaccinated has advised 3 doses of HPV vaccine are needed due to immunocompromise/a weak immune system). ☐
- I confirm by signing this form that I am authorised to give consent on behalf of the above named student. (People aged 16 years or older are legally entitled to consent for themselves)

Signature: ____ Consent Date: D D M M Y Y Y Y

Signature: ____

Name *(Please print)*: ____

(Please tick): Parent ☐ Legal Guardian ☐ Self ☐

PART 3 Please tick the box if you do not consent to receiving the HPV vaccine and sign to say **NO**

No, I do not consent to the vaccination of the above named student with:

HPV ☐

- I have read and understand the accompanying vaccine information, including known side effects.
- I confirm by signing this form that I am authorised to refuse consent on behalf of the above named student. (People aged 16 years or older are legally entitled to consent for themselves)

Signature: ____ Date: D D M M Y Y Y Y

Signature: ____

Name *(Please print)*: ____

(Please tick): Parent ☐ Legal Guardian ☐ Self ☐

Reason for Refusal: ____

FOR OFFICE USE ONLY

Name: ______ Date of Birth: ______ Client ID: ______

(If applicable) Class: ______ School Roll Number: ______

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VISIT 1 HPV (Dose one)

HPV Dose	Date Given	Batch Number	Prescribed by signature and MCRN/PIN	Vaccinator's signature and PIN/MCRN	Injection Site (Circle as appropriate)	
1	D D M M Y Y Y Y				Right Deltoid	Left Deltoid

Time Vaccinated: **AM/PM** Vaccination Location: School ☐ Clinic ☐

Clinic Name:

Completed by: ______ **MCRN/PIN:** ______ D D M M Y Y Y Y
(if applicable)

If vaccine not administered please state why? DNA or Absent ☐ Refused on the Day ☐

Vaccine Contraindicated ☐ Deferred ☐ Other ______

VISIT 2 HPV (Dose two) if immunocompromised

HPV Dose	Date Given	Batch Number	Prescribed by signature and MCRN/PIN	Vaccinator's signature and PIN/MCRN	Injection Site (Circle as appropriate)	
2	D D M M Y Y Y Y				Right Deltoid	Left Deltoid

Time Vaccinated: **AM/PM** Vaccination Location: School ☐ Clinic ☐

Clinic Name:

Completed by: ______ **MCRN/PIN:** ______ D D M M Y Y Y Y
(if applicable)

If vaccine not administered please state why? DNA or Absent ☐ Refused on the Day ☐

Vaccine Contraindicated ☐ Deferred ☐ Other ______

VISIT 3 HPV (Dose three) if immunocompromised

HPV Dose	Date Given	Batch Number	Prescribed by signature and MCRN/PIN	Vaccinator's signature and PIN/MCRN	Injection Site (Circle as appropriate)	
3	D D M M Y Y Y Y				Right Deltoid	Left Deltoid

Time Vaccinated: **AM/PM** Vaccination Location: School ☐ Clinic ☐

Clinic Name:

Completed by: ______ **MCRN/PIN:** ______ D D M M Y Y Y Y
(if applicable)

If vaccine not administered please state why? DNA or Absent ☐ Refused on the Day ☐

Vaccine Contraindicated ☐ Deferred ☐ Other ______