SKOLHÄLSAN

VACCINATION PERMISSION

☐ **Yes, I give my consent to let my child be vaccinated against HPV with Gardasil.**

☐ **No, I don't want my child to be vaccinated against HPV with Gardasil.**

Name:_____ **Personal ID number:**_____

School:_____ **Class:**_____

This vaccine protects your child against HPV which can lead to cervical cancer. The vaccine is being given during two different occasions with a couple of months between every injection.

Has your child previously been given a vaccine against HPV? ☐ Yes ☐ No
If yes, which vaccine:_____
Number of doses:_____
When was the vaccine taken:_____

Has your child reacted strongly to previous vaccinations? ☐ Yes ☐ No
If yes, which vaccine and when:_____

Has your child had a severe allergic reaction against something that it has been necessary for you to seek medical care? ☐ Yes ☐ No

Has your child been given any vaccine the last 2-4 weeks? ☐ Yes ☐ No
If yes, which vaccine:_____

Does your child suffer from haemophilia or any other bleeding diathesis? ☐ Yes ☐ No

Has your child any other severe chronic disease? ☐ Yes ☐ No
If yes, which:_____

Is your daughter pregnant? ☐ Yes ☐ No

_____ _____
Parent/guardian signature **Mobile phone**

_____ _____
Clarification of signature **Date**

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