SKOLHÄLSAN

VACCINATION CONSENT FORM

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

☐ **No, I don't want my child to be immunized 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 given on two different occasions with a few months in between.

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

Has your child reacted strongly to previous immunizations? ☐ 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 in 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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