BRITISH COLUMBIA | Ministry of Health

CONSENT FOR HUMAN PAPILLOMAVIRUS (HPV) IMMUNIZATION

Last Name	First Name	School	Div / Teacher

Preferred Name	Name of Parent / Guardian / Representative	Relationship to Child

Birthdate (YYYY / MM / DD)	Personal Health Number (PHN)	ALERT	Has your child ever had a serious or life-threatening allergic reaction? ◯ No ◯ Yes (To What?):
Primary Contact Number	Secondary Contact Number		Is your child's immune system affected by a severe disease or medication? ◯ No ◯ Yes

PARENT / GUARDIAN / REPRESENTATIVE – For the vaccine listed below, check Yes or No, sign and date.
I understand the information in the HealthLinkBC File for the vaccine listed below. I understand the benefits and possible reactions for the vaccine and the risk of not getting immunized. I understand that in the rare occurrence of anaphylaxis, emergency treatment will be provided. I have had the opportunity to ask questions that were answered to my satisfaction. I understand this consent is valid for two years for the vaccine series listed below unless I cancel it.

Mature Minor Consent: Parents/guardians and representatives should make every effort to discuss the information in the HealthLinkBC File for the vaccine listed below with the child, and to involve the child as much as possible in the decision to provide consent to immunization. Although a child may be immunized with the consent of a parent/guardian or representative, a child is entitled to be informed about immunization and may provide consent to immunization if the person administering the vaccine is sure that the child understands the benefits of, and possible reactions to, the vaccine, and the risk of not getting immunized.

PARENT / GUARDIAN / REPRESENTATIVE USE ONLY			PUBLIC HEALTH USE ONLY – CHILD'S IMMUNIZATION RECORD				
Human Papillomavirus 9 (HPV9) vaccine							
If your child has had one or more doses of any HPV vaccine, please give dates:				Date YYYY / MM / DD	SITE	LOT #	NURSE SIGNATURE
1. YYYY / MM / DD	2. YYYY / MM / DD	3. YYYY / MM / DD	1ST DOSE		◯ LA ◯ RA		
I want my child immunized: ◯ **Yes** ◯ **No**			2ND DOSE		◯ LA ◯ RA		
Signature	Date (YYYY / MM / DD)		3RD DOSE		◯ LA ◯ RA		
			☐ **Series Complete - no further doses required** NURSE'S NOTES				

PUBLIC HEALTH USE ONLY – MATURE MINOR CONSENT		
I want to be immunized for HPV9: ◯ **Yes** ◯ **No**	Nurse Signature	Date (YYYY / MM / DD)
Child Signature: _____	Mature Minor ROI Sensitive Record ◯ Yes ◯ No	Time ◯ AM ◯ PM

PUBLIC HEALTH USE ONLY – TELEPHONE CONSENT			
Telephone Consent Obtained From	For **HPV9** ◯ **Yes** ◯ **No**	Phone Number Called	Date (YYYY / MM / DD)
Relationship To Child		Nurse Signature	Time ◯ AM ◯ PM

Personal information collected on this form will be used by the health authority to update the student's immunization record. The information will be used and disclosed in accordance with the *Freedom of Information and Protection of Privacy Act*. Summary statistical information may be reported to the Ministry of Health. If you have any questions about the collection and use of this personal information, contact your local public health nurse. You may be contacted to request your participation in the evaluation of this school immunization program.

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