

## HUMAN PAPILOMAVIRUS (HPV) VACCINE – SECOND DOSE ONLY

PLEASE COMPLETE SECTIONS 1 AND 2

SECTION 1: STUDENT'S PERSONAL INFORMATION					
SCHOOL		GRADE	TEACHER (HOMEROOM)		
LAST NAME		FIRST NAME		DATE OF BIRTH (YYYY / MM / DD)	
BIRTH GENDER <input type="checkbox"/> M <input type="checkbox"/> F	MEDICARE #	NAME OF PARENT / LEGAL GUARDIAN			
DAYTIME PHONE (work or home) <input type="checkbox"/> CELL		OTHER DAYTIME PHONE <input type="checkbox"/> CELL		PARENT'S / LEGAL GUARDIAN'S EMAIL	
<b>A L E R T</b>	DOES YOUR CHILD HAVE ALLERGIES? <input type="checkbox"/> NO <input type="checkbox"/> YES*				
	*IF YES, TO WHAT AND WHAT TYPE OF REACTION:				
	DOES YOUR CHILD HAVE A HEALTH PROBLEM? <input type="checkbox"/> NO <input type="checkbox"/> YES*				
	*PLEASE EXPLAIN:				
DOES YOUR CHILD TAKE ANY MEDICATIONS? <input type="checkbox"/> NO <input type="checkbox"/> YES*					
*PLEASE LIST :					

SECTION 2: PARENT / GUARDIAN CONSENT	
<b>For the vaccine, check YES or NO, sign and date.</b>	
Your signature will confirm the following:	
<ul style="list-style-type: none"> <li>I have read the information I was given on the Human Papillomavirus (HPV) vaccine.</li> <li>I understand the benefits and possible reaction(s) for the vaccine and the risk of not getting immunized.</li> </ul>	
If you have any questions, please call your local Public Health office.	

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<input type="checkbox"/> YES, vaccinate my child.	
<input type="checkbox"/> NO, do not vaccinate my child.	
If no, please specify : _____	
Signature of parent/legal guardian ➔	Date (YYYY / MM / DD)

### FOR PUBLIC HEALTH NURSE USE ONLY

SECTION 3 : TO BE COMPLETED BY PUBLIC HEALTH NURSE							
HPV	Lot #	Site	Route	Dosage	Date (YYYY/MM/DD)	Time	Signature
<input type="checkbox"/> GARDASIL 9 DOSE 2		<input type="checkbox"/> Right arm <input type="checkbox"/> Left arm	<input type="checkbox"/> IM	<input type="checkbox"/> 0.5 mL			

SECTION 4: PERSONAL IMMUNIZATION RECORD	
This section is to be completed by the Public Health nurse. The immunization record will be given to your child after their immunization. Please keep this record with your child's personal health files.	

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STUDENT'S NAME _____	
DOB (YYYY / MM / DD) _____	
MEDICARE # _____	
NAME OF VACCINE:	DATE (YYYY / MM / DD)
<input type="checkbox"/> GARDASIL 9	TIME _____
NURSE'S SIGNATURE _____	

