Today's Date _____ Name (please print) _____ Date of Birth _____

HPV VACCINATION CONSENT [INJ # _____]

Are you sick today? ☐ yes ☐ no

Do you have any known allergies to food, medications or any vaccine? ☐ yes ☐ no
Please list:

Have you ever had a serious reaction after receiving a vaccination? ☐ yes ☐ no

Did you bring your vaccination record card with you today? ☐ yes ☐ no

Do you have cancer, leukemia, AIDS or any other immune system problem? ☐ yes ☐ no

Do you take cortisone, prednisone, other steroids or anti-cancer drugs
or have you had any X-ray treatments in the past 3 months? ☐ yes ☐ no

Have you had a seizure or a brain or other nervous system problem?

During the past year, have you received a transfusion of blood or blood products
or been given a medicine called immune (gamma) globulin or an anti-viral drug? ☐ yes ☐ no

Are you pregnant or is there a chance you could become pregnant in the next 3 months? ☐ yes ☐ no

Have you received any vaccinations in the last 4 weeks? ☐ yes ☐ no

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I have read the Vaccine Information Sheet about HPV and the HPV vaccine that I received today.
I have had a chance to ask questions that were answered to my satisfaction.
I understand the benefits and risks of the vaccine and ask that the vaccine be given to me / my child.
I understand that there are a total of 3 injections that must be administered for the vaccine to be completely effective.
I understand that vaccination does not substitute for routine cervical cancer screening.
I agree to remain in the clinic for 15 minutes after my immunization (shot) for observation.

Client Signature _____ Date _____

Guardian Signature (if client is under 18) _____ Date _____

Interpreter Signature _____ Date _____

For patients over 26 years old only, OFF-LABEL USE CONSENT
This vaccine is approved by the Federal Drug Administration for girls and women aged 9 to 26. Although you are older than 26, you may still derive some benefit from the HPV vaccine, but you are opting to use this vaccine "off label." As such, you are assuming any vaccine risks. By signing below you release the Boulder Valley Women's Health Center and its employees from any liability associated with administration of this vaccine to you.

Client Signature _____ Date _____

Women's Health - 2855 Valmont Road **Boulder**, CO 80301 / 82 21st Ave **Longmont,** CO 80501 / **Phone:** 303-442-5160 / **Fax:** 303-440-8769