Consent for Gardasil 9® Vaccine

Date (D/M/Y):	Name (Last, First):	
Provincial Health Number (PHN):		
Address:	City:	Postal Code:
Home Phone:	Mobile:	Email:
Date of Birth (D/M/Y):	Age:	☐ Male ☐ Female ☐ Transgender

HPV Vaccine Questionnaire

Do you or anyone in your close contacts have Covid-19 symptoms? ☐ Yes ☐ No

Have you had any HPV vaccine before? ☐ Yes ☐ No

Have you ever had any reaction to any vaccine? ☐ Yes ☐ No

Are you or do you think you might be pregnant? ☐ Yes ☐ No

Do you qualify for the HPV publicly funded vaccine?

☐ Grade 6 students – routine immunization program
☐ Boys born in 2005
☐ Girls who did not get the vaccine in grade 6 – if they start their vaccine series before age 19 and complete before age 26
☐ HIV positive and transgender individuals 9-26 years of age who have not received a complete series of HPV
☐ Men 9-26 years of age who have sex with other men, questioning their sexual orientation, and/or are street involved.
☐ Boys 9-18 years of age in the care of the Ministry of Children and Family Development (MCFD)
☐ Boys and men of any age who are in youth custody services centers

Do you fall under any of the following categories? (recommended but not provided free in BC):

☐ Women 19-45 years of age
☐ Males 9-26 years of age (who are not indicated above)
☐ Males 27 years of age and older who are men who have sex with men

*according to new NACI guidelines there is no upper age limit for receiving the vaccine and it is recommended for both men and women.

Do you have any food/drug/vaccine allergies? _____

Consent Given by Patient/Agent

I, the undersigned client, parent or guardian, have read or had explained to me information about the HPV vaccine (GARDASIL®9). I have had the chance to ask questions, and answers were given to my satisfaction. I understand the risks and benefits of receiving the HPV vaccine. I agree to wait in the pharmacy for 15 minutes after receiving the vaccine.

Appt Date Here

Patient/Agent Name (& Relationship)	Patient/Agent Signature	Date Signed (D/M/Y)
_____	_____	_____

Pharmacy / RN Use Only

Pharmacist Signature: _____
License # : _____
Date of Immunization: _____ ☐ Same as above
Time of Immunization: _____
Administered according to guidelines: Immunize BC ☐ Yes
National Advisory Committee on Immunization Guidelines (NACI) ☐ Yes

Name of Vaccine: **GARDASIL®9**
Vaccine Lot#:
_____
Vaccine Expiry Date (MM/YYYY):
_____
Site: Arm ☐ Left ☐ Right