HPV Vaccine - GARDASIL®9
Consent for Immunization

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 contact have any Covid-19 symptoms? ☐ Yes ☐ No ☐ Not sure

Have you had any HPV vaccine before? ☐ Yes ☐ No ☐ Not sure

Have you ever had any reaction to any vaccine? ☐ Yes ☐ No ☐ Not sure

Are you or do you think you might be pregnant? ☐ Yes ☐ No ☐ Not sure

Do you qualify for the HPV publicly funded vaccine?

☐ Grade 6 students – routine immunization program.

☐ HIV positive individuals 9-26 years of age who have not received a complete series of HPV

Males 9-26 years of age at the time of series commencement who are: ☐ 1- men who have sex with men (including those who are not yet sexually active and are questioning their sexual orientation) ☐ 2- street involved

☐ Males 9-18 years of age in the care of the Ministry of Children and Family Development (MCFD)

☐ Males in youth custody services centres

☐ Transgender individuals 9-26 years of age

☐ A series commenced prior to age 19 may be completed with publicly funded HPV vaccine prior to the 26th birthday

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

☐ 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

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.

PUT YOUR APPOINTMENT DATE HERE

_____ _____ _____

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

Pharmacy Use Only

Pharmacist Signature: _____

License # : _____

Date of Immunization: _____ ☐ Same as above

Time of Immunization: _____

Name of Viccine: **GARDASIL®9**

Vaccine Lot#: _____

Vaccine Expiry Date (MM/YYYY): _____

Site: Arm ☐ Left ☐ Right