

Dear Parent/Guardian

ARM AGAINST CERVICAL CANCER

Human Papillomavirus (HPV) Vaccine is available for all girls under 18 years

The human papillomavirus (HPV) vaccine that protects against cervical cancer is available to all girls prior to their 18th birthday. By having this vaccination, your daughter will be protected against the commonest cause of cervical cancer for many years to come. Recent evidence indicates this vaccine can be reduced to an effective two dose course and for best protection it is important your daughter receives both injections.

Gardasil became the vaccine of choice in September 2012, it protects against the two types of HPV virus that cause more than 70 per cent of cervical cancer in England and two types of HPV virus that cause 90 per cent of genital warts. Please read all the information carefully then complete and return the attached consent form to your child's school within one week. This vaccine is **not** available via your GP.

Name of product: GARDASIL

The intended benefits: To protect females against diseases caused by infection with Human Papillomavirus (HPV) types 16 and 18; responsible for approximately 70% of cervical cancer cases; HPV types 6 and 11 responsible for approximately 90% of genital wart cases.

These diseases include: cervical cancer (cancer of the cervix i.e. lower part of the uterus or womb); precancerous cervical lesions (changes to the cells of the cervix that have a risk of turning into cancer); genital warts.

Possible side effects:

- **Very commonly** (more than 1 in 10 patients); side effects found at the injection site include: pain, swelling and redness. Headache was also seen.
- **Commonly** (more than 1 in 100 patients); side effects found at the injection site include: bruising, itching, pain in extremity. Fever and nausea have also been reported.
- **Rarely** (less than 1 in 1000 patients); hives (urticaria).
- **Very Rarely** (less than 1 in 10,000 patients); difficulty breathing (bronchospasm) has been reported.

Children with an impaired immune response, whether due to the use of potent immunosuppressive therapy, a genetic defect, Human Immunodeficiency Virus (HIV) infection, or other causes may not respond to the vaccine.

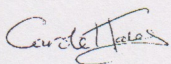
The vaccine will be given into the muscle of the upper arm; the first injection at an arranged date with school; and the second injection, approximately 6-12 months following the first injection. (Guidance advises any gap between doses of 6 and 24 months is clinically acceptable) Those children who are absent from school on any of the given dates but have returned a signed consent form will be offered the vaccine on subsequent visits to the school or via community clinic's.

Further information is available on www.nhs.uk/vaccinations or you can contact the Immunisation Team on the above phone number. If you wish to access further advice and information about how to support your child in managing any anxiety about this injection, this is available on www.shropscommunityhealth.nhs.uk.

The NHS Friends and Family Survey is a way of gathering your feedback about your experience and helps to drive improvement in our service. To complete the online survey please use the following link:

<http://www.shropscommunityhealth.nhs.uk/fft-survey>

Yours sincerely



Carole Hales
BCG/HPV Co-ordinator

Immunisation Date
Friday 10th February 2017

Second injection will be in
approximately 6 -12 months

HUMAN PAPILLOMAVIRUS (HPV) VACCINATION CONSENT FORM

Name of proposed procedure: HPV VACCINATION - GARDASIL

Dear Parent/Guardian

Please complete the following details and return to school within one week.

Last name	First name/s	Date of Birth
Home address		Daytime contact telephone number for parent/guardian
Post Code	NHS number (if known)	
School/College		Year group/form
GP name and address		

Consent for two HPV vaccinations (Please complete **one** box only)

I want my daughter to receive the full course of two HPV vaccinations, as the parent/guardian with parental responsibility I consent;	I do not want my daughter to have the HPV vaccine, as the parent/guardian with parental responsibility I do not consent;
Signature:	Signature:
Print Name:	Print Name:
Date:	Date:

If, after discussion, you and your daughter decide that you do **not** want her to have the vaccine, it would be helpful if you would give the reasons for this on the back of the form and return to the school. Please turn over to complete further information. **Any side effects following the HPV vaccination should be reported to the Immunisation Team, School Nurse or your GP please see attached information letter.** Information about the vaccinations will be put on your daughter's health records, including records at her GP's surgery and those held by the NHS. Thank you for completing and returning this form.

Statement of Health Professional; I have explained the procedure to the patient. Information leaflets have been sent to the patient/parent/guardian. In particular, I have explained:

The intended benefits; to offer protection against cervical cancer and genital warts. I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient. The following leaflet has been supplied; **Arm against cervical cancer or 123 Against HPV.**

FOR OFFICIAL USE ONLY

Vaccine: GARDASIL Dose: 0.5ml x 2 IM	Site of Injection (please circle)		Batch number/ expiry date	Immuniser (legible signature/print)	Date Vaccine Given	Time
First HPV vaccination	L arm	R arm				
Second HPV vaccination	L arm	R arm				

This is a once only vaccination course, if your daughter has already received 2/3 doses of HPV vaccine, either Cervarix or Gardasil she does not require any further injections. If you are unsure of her immunisation details please contact the Child Health Department, phone: 01743 450800 and ask for the Immunisation clerks and we will contact the appropriate services to obtain her immunisation details.

If your child has already received this vaccine, please tell us here with the date/s:	
Has your child received any vaccinations in the last 12 months? If yes please give details and date:	
Has your child ever had an adverse reaction to a vaccine? If yes please give details:	
Does your child have any general health problems? Please give details:	
Is your child taking any regular medication? Please give details:	
Does your child have any allergies? Please give details:	
If your child has an on-going medical condition or communication difficulties that you would like to tell us about to assist the immunising nurses, please give details:	

For Office Use Only: Comment Sheet for Vaccinations & Immunisations

Patient Name:		NHS Number:		Signature:
Date & Time	Comments	Signature		