

## Informed Consent for HPV Vaccine Series

Date:

Patient Name:

Date of Birth:

I \_\_\_\_\_ (Print Name) the legal parent or guardian for  
\_\_\_\_\_ (Patient Name) give permission to receive the  
Human Papilloma Virus (HPV) vaccination series.

**By signing this consent form I agree to the following:**

- 1) I will allow my child to return for vaccination and receive the HPV vaccine dose 1, 2, or 3, even when I'm not accompanying him/her to the visit.
- 2) I have been given a copy of the most recent version of the Vaccine Information Sheet (VIS) for the HPV vaccine

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Note: to be scanned in patient chart.