



559-635-7707

GARDASIL IMMUNIZATION CONSENT

Human Papillomavirus (HPV)

HPV is a common virus that is spread through sexual activity that involves genital contact. There are over 100 types of HPV; some cause no harm while types 6, 11, 16, and 18 can cause cervical cancer. In the United States, approximately 20 million people are infected with HPV by age 50. Cervical cancer is the second most common cause of cancer death in women worldwide, resulting in nearly a half-million diagnoses and 240,000 deaths.

Vaccine

Gardasil is a non-infectious recombinant, quadravalent vaccine that helps protect against diseases caused by Human Papillomavirus (HPV) Types 6, 11, 16, and 18. It has been recommended for girls and women 9 through 26 years of age. The usual immunization regimen consists of three doses: dose 1 given at elected date, dose 2 two months later and dose 3 six months after the first dose.

Risks and Possible Side Effects

Gardasil (HPV) vaccine has been shown to be well tolerated and highly immunogenic. As with any vaccine, however, it is possible that expanded commercial use of the vaccine could reveal rare adverse reactions. The most frequently reported adverse reactions were pain, swelling, itching and redness at the injection site and fever. Difficulty breathing (bronchospasm) has been reported very rarely.

Contraindication

Vaccination is generally not recommended for the following people:

1. Allergic reaction to previous dose or allergy to any vaccine components.
2. Acute febrile illnesses ($>100^{\circ}$ F/ 37.8° C).
3. Pregnancy.
4. Weakened immune system due to genetic defect or HIV infection

If you have any of the above, please notify the staff. If you have any questions, please ask now or check with your physician before receiving the vaccine.

If you experience any significant reactions, see your physician.

For Clinic Use

Date of Vaccination: _____ Manufacturer & Lot #: _____ Site: IM Right Left

Administered By: _____ Clinic Site: _____ Payment: _____

I have read the above information about HPV and HPV vaccine, and I have had a chance to ask questions. I understand the benefits and risks of HPV vaccination and request that the vaccine be given to me.

Information-Person to Receive Vaccine

Name: _____ Date of Birth: _____ Age: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Signature: _____ Daytime Phone #: _____