

Client Label

## Family Planning Association of Chelan-Douglas Counties

900 Ferry Street • Wenatchee, WA 98801 • (509) 662-2013

### Gardasil Consent Form

I have received and read the information fact sheet regarding HPV and the Gardasil vaccine. I understand the benefits and risks of the Gardasil vaccine and consent to be immunized against certain strains of HPV, by receiving three (3) injections of the Gardasil vaccine.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

HOLE PUNCH

	First Dose	Second Dose	Third Dose
<b>VIS to Client:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	____/____/____	____/____/____
Are you pregnant?	Yes No Unsure	Yes No Unsure	Yes No Unsure
Any prior hypersensitivity or allergy to vaccines/vaccine products?	Yes No Unsure	Yes No Unsure	Yes No Unsure
Any bleeding disorders? If yes, specify:	Yes No	Yes No	Yes No
I have already begun receiving Gardasil.	Yes No <small>When:</small>	Yes No <small>When:</small>	Yes No <small>When:</small>
Any side effects or concerns with previous vaccines? If yes, specify:	Yes No	Yes No	Yes No

#### Clinic Use Only

	First Dose	Second Dose	Third Dose
Label:	Affix Med Label Here	Affix Med Label Here	Affix Med Label Here
Site: _____ Given by: _____	Site: _____ Given by: _____	Site: _____ Given by: _____	Site: _____ Given by: _____
Imm Record Doc: <input type="checkbox"/> Yes <input type="checkbox"/> No	Imm Record Doc: <input type="checkbox"/> Yes <input type="checkbox"/> No	Imm Record Doc: <input type="checkbox"/> Yes <input type="checkbox"/> No	Imm Record Doc: <input type="checkbox"/> Yes <input type="checkbox"/> No
Notes: _____	Notes: _____	Notes: _____	Notes: _____

**ORDER:** Gardasil 0.5 ml Administer IM-deltoid preferred or vastus laterals. Provider: \_\_\_\_\_ Date: \_\_\_\_\_

