AGE:

THE CITY UNIVERSITY OF NEW YORK
IMMUNIZATION CONSENT FORM FOR HPV VACCINATIONS

COLLEGE	TELEPHONE	EMERGENCY CONTACT #			
LAST NAME		FIRST			M.I.
□ MALE □ FEMALE □ MTF □ FTM	MOTHER'S MAIDEN NAME		DATE OF BIRTH Month	Day	Year
ADDRESS	APT.	CITY	STATE	ZIP	

SCREEN A

ALL INFORMATION PROVIDED WILL BE KEPT CONFIDENTIAL

Check the appropriate box (es)

1. Do you have health insurance? □ **YES** □ **NO**
2. If yes, who is your health insurance from?

□ Health Care Exchange Plan
□ Medicaid
□ Sponsored by Parent/Guardian
□ Private(Aetna, BlueCross, HIP)________________
□ Uninsured
□ Underinsured

Covered by:
□ Spouse
□ Domestic Partner
□ Employee

SCREEN B

	CIRCLE ONE		
1. Are you sick with anything other than a cold today?	**YES**	**NO**	**DON'T KNOW**
2. Have you ever had a HPV vaccination?	**YES**	**NO**	**DON'T KNOW**
b. If yes, when: ________________			
3. Do you have any allergies to medications, vaccines or latex?	**YES**	**NO**	**DON'T KNOW**
a. If so, please list: ________________			
b. What type of allergic reaction did you have?________________			

FOR FEMALES ONLY

4. Are you pregnant now?	**YES**	**NO**	**DON'T KNOW**
a. Date of last menstrual period?________________			

Interviewed by: ________________

CONSENT

I have read the information contained in the Vaccine Information Statement about the disease(s) and the vaccine(s). I have had a chance to ask questions which, if any, were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated below be given to me or to the person named for whom I am authorized as parent, guardian, or long term custodian to make this request.

Yo he leido la Declaracion de Vacunas acerca de la(s) enfermedad(es) y la(s) vacuna(s). He tenido la oportunidad de hacer preguntas las cuales, si hubo algunas, fueron contestadas a mi satisfaccion. Creo que comprendo los beneficios y riesgos de la(s) vacuna(s) y pido que me den la(s) vacuna(s) indicada(s) mas abajo a mi o a la persona nombrada por quien estoy autorizado(a) como padre, guardian, o cuidador por largo tiemp[o para hacer esta peticion.

PATIENT/PARENT SIGNATURE
FIRMA DEL PACIENTE/PADRE ________________ **DATE**
FECHA ________________

OFFICE USE ONLY

Vaccine	Dose #	Dosage	V.I.S. Date	Injection Site	Manufacturer I.D.	Lot #	Expiration Date
Gardasil				LUA/RUA			

Innoculator Signature: **Date:**

Student Health Services Office - 12/18/2014