

# GARDASIL VACCINE CONSENT

## PATIENT AUTHORIZATION AND NOTICE

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

### ADULT IMMUNIZATIONS – Screening Questionnaire (PLEASE READ)

The following questions will help us determine which vaccines you may be given today. If you answer “YES” to any question, it does not necessarily mean you should not be vaccinated, it just means additional questions must be asked. **If a question is not clear, please ask your healthcare provider to explain it.**

### GARDASIL VACCINE QUESTIONS:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Are you sick today?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you have allergies to medications, foods, or vaccines?<br><i>Including gelatin or the antibiotic neomycin or any other component of the shingles vaccine.</i> | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Have you ever had a serious reaction after receiving a vaccination?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you have a long-term health problem with heart disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorders?         | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you have cancer, leukemia, AIDS, or any other immune system problems?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Do you take cortisone, prednisone, other steroids, or anticancer drugs or have you had radiation treatments?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Have you had a seizure or other nervous system problem?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| During the past year have you received a transfusion of blood or blood products?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| For women: Are you pregnant or is there a chance you could become pregnant?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Have you received any vaccinations in the past 4 weeks?  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

I certify that I have been given the GARDASIL CDC Vaccine Information Statement before my injection. I have reviewed the information sheet; understand the possible side effects and I feel I have no contraindications to the administration of the vaccine.

**\* I UNDERSTAND THIS VACCINATION IS GIVEN IN (3) SEPARATE DOSES AND I AM RESPONSIBLE TO PAY FOR EACH DOSE.**

\_\_\_\_\_  
Signature of Recipient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Vaccine Manufacturer

\_\_\_\_\_  
Lot Number

\_\_\_\_\_  
Exp. Date

\_\_\_\_\_  
Signature of Nurse

Injection Site:

Right Arm

Left Arm