Stadt Wien | Gesundheitsdienst

DECLARATION OF CONSENT to the VACCINATION AGAINST HUMAN PAPILLOMVIRUS (HPV) with Gardasil 9®

PLEASE ANSWER THE FOLLOWING QUESTIONS (Please tick as applicable)	Yes	No
Has your child ever had **severe complaints or adverse effects**, following a vaccination, except for minor adverse effects such as redness, swelling, pain at the injection site or a mild temperature? If yes, which one(s)?	☐	☐
Does your child currently have a **high temperature** or has your child had a high temperature in the past two weeks? Does your child currently have a cough, head cold or sore throat? Does your child currently have any other kind of infection?	☐	☐
Does your child have any **allergies** (e.g. egg protein, types of medication)? If yes, which one(s)? ..... If your child is currently receiving an injection therapy to treat allergies: When did your child receive the last injection? ..... When will your child receive the next injection?	☐	☐
Does your child have a congenital or acquired **immune deficiency / immune system disorder**? If yes, which one?	☐	☐
Does your child take **medication** (e.g. cortisone, cytostatics, blood thinning medication) on a regular basis? If yes, which medication?	☐	☐
Is your child currently undergoing **chemotherapy and/or radiation therapy**?	☐	☐
Does your child have a **severe** or **chronic illness** (e.g. cancer, autoimmune disorder, blood clotting disorder)? If yes, which one?	☐	☐
Has your child recently undergone invasive therapy (e.g. surgery)?	☐	☐
Does your child have a **chronic inflammatory disease of the brain or spinal cord**? ..... Has your child ever had an **epileptic fit**?	☐ ☐	☐ ☐
Did your child receive **blood, blood products or immunoglobulins** in the **past three months**? If yes, when?	☐	☐
Please tick if your child is **pregnant**.	☐	☐
Did your child receive any other **vaccination(s)** in the **past four weeks**? If yes, which one(s) and when?	☐	☐

Please turn the page – Thank you!

Please write in capital letters – thank you!

Name of school

Class

Last name/surname of child

First name of child

Address

Social insurance number and date of birth of child: XXXX day/month/year

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Name of parent or legal guardian

Social insurance number and date of birth of parent or legal guardian: XXXX day/month/year

I hereby confirm with my signature that I have carefully read and understood the information sheet and the package leaflet for the abovementioned vaccine (Gardasil 9®). I have been informed about the composition of the vaccine as well as any contraindications for its administration and any potential side effects of the vaccination and have understood this information.

I have been given the opportunity to discuss any open questions with the physician during the office hours of the School Medical Service. However, I have been sufficiently informed about the benefits and risks of the vaccination and, therefore, do not need to talk to the school physician in person.

I consent to the transfer of my data to the City of Vienna's Public Health Services to enable them to compile anonymised statistics on behalf of the Austrian Federal Ministry of Social Affairs, Health, Care and Consumer Protection (BMSGPK).

I hereby consent to my child receiving the vaccination.

.....
Date

.....
Signature of parent or legal guardian

PLEASE NOTE:
If you want to talk to the school physician in person during the office hours of the School Medical Service, please sign this declaration of consent only after you have discussed the vaccination with the school physician and hand it over to them in person.

Batch number:

Remarks by physician:

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Date

.....
Stamp and signature of physician