UNIVERSITY OF ILLINOIS SPRINGFIELD
Health Services • BSB 20 • (217) 206-6676 • Fax (217) 206-7779
uishealthservice@uis.edu

Quadrivalent Human Papilloma Virus (HPV) Vaccination
Consent & Administration Form

Place sticker:

Student name: _____

UIN: _____

DOB: _____

Age: _____

Telephone: _____

Student address: _____

Current medications

Please list your current medication. Include prescription medication and over the counter medications/drugs:

_____

_____

_____

_____

_____

_____

Allergies

Please list any allergies that you may have:

_____

_____

_____

Medical history

Before receiving an injection, I will ask questions of the provider if I have any.	☐
I will inform the provider of any allergies BEFORE receiving the vaccine.	☐
I am 46 years of age or younger. (See medical provider if over 46 and started series).	☐
I am not allergic to Baker's yeast.	☐
I do not have an acute illness or infection.	☐
I have received and read the Vaccine Information Statement on the HPV vaccine, including contraindications and side effects.	☐
I do not have a clotting disorder or a weakened immune system, such as HIV, or caused by a genetic disorder or by other disease or medication.	☐
I understand that the vaccination does not replace the need for routine cervical screening and I also understand that vaccination does not protect everyone who is vaccinated. I understand that this vaccination does not prevent any other disease beside HPV nor does it cure me if I already contracted it.	☐
I am not on blood thinners, anticoagulants or have a bleeding disorder.	☐
I do not have a fever greater than 100 degrees Fahrenheit or 37.8 Celsius today.	☐
I understand that I should report any adverse reactions to Health Services at (217) 206-6676.	☐
I am not pregnant or breast feeding.	☐
I believe I understand the benefits and risks of the vaccine(s) and request that it be given to me.	☐
I agree to remain in the Health Services Clinic for 15-20 minutes following injection to be observed for any sign of adverse reaction.	☐

Student Signature _____ Date: ____/____/____

HEALTH SERVICES USE ONLY

VIS form given: ☐ **Yes** ☐ **No** VIS form date: ____/____/____ VIS given by: _____

HPV Administration

Has advice been given about the requirements for 3 doses (a full course)? ☐ **Yes** ☐ **No**

Has patient been advised of side effects (inflammation at vaccine site and slight malaise for a day or two)? ☐ **Yes** ☐ **No**

1. Name of vaccine: _____ ☐ **Lot number:** _____ **Expiration date:** ____/____/____

Route: ☐ IM Site of vaccination: ☐ RT deltoid ☐ LT deltoid Nurse Signature: _____ Date: _____

2. Name of vaccine: _____ ☐ **Lot number:** _____ **Expiration date:** ____/____/____

Route: ☐ IM Site of vaccination: ☐ RT deltoid ☐ LT deltoid Nurse Signature: _____ Date: _____

3. Name of vaccine: _____ ☐ **Lot number:** _____ **Expiration date:** ____/____/____

Route: ☐ IM Site of vaccination: ☐ RT deltoid ☐ LT deltoid Nurse Signature: _____ Date: _____

Printed by Authority of the State of Illinois 0719-50-56401