





## Dear student, parent / guardian

Girls and young women can receive a FREE vaccine to protect against infection with some types of Human Papillomavirus (HPV) that can cause cervical cancer. This vaccine, GARDASIL®, is offered at school to female students in Years 8–13 by a public health nurse. The vaccine is given by three injections into the upper arm over 6 months.

The information on this page and the next explain what GARDASIL® is, how it works, and what the benefits are, to help you to decide if you would like to consent to receiving the vaccine at school.

Girls and young women will only be vaccinated at school if this consent form is completed, signed and returned to school.

### GIVING CONSENT

- Young women 16 years and over, may choose to fill in and sign this consent form for themselves.
- Girls and young women under 16 need a parent or guardian to fill in and sign the consent form.

If you have any questions about the vaccine or this consent form, the public health nurse will be able to help you. Their contact details are on the top of page 8. The public health nurse will contact you if they have any questions about the information you provide on the consent form.

## About the vaccine

### What is the HPV vaccine?

The HPV vaccine is called GARDASIL®. It protects against four types of HPV: two types of HPV that cause 70% of cervical cancer and two types of HPV that cause 90% of genital warts.

### What is cervical cancer?

Cervical cancer is cancer of the cervix. The cervix is the lower part of the uterus or womb.

### What causes cervical cancer?

HPV is a very common virus that is spread through sexual contact. Four out of five people become infected at some time during their lifetime. Most HPV infections clear by themselves, but some infections can lead to cervical cancer many years later.

### Why vaccinate?

Every year in New Zealand about 160 women are diagnosed with cervical cancer and 60 die from it. Vaccinating girls and young women against 2 types of HPV that can cause cervical cancer will reduce their chances of getting cervical cancer later in life. It also helps to prevent other health problems caused by the other 2 types of HPV, like genital warts.

### How effective is the vaccine?

The vaccine is highly effective in preventing some of the types of HPV that can cause cervical cancer. Protection is expected for 5 years, but the exact period of protection is unknown. Ongoing studies will measure how long protection lasts.

The vaccine only prevents HPV infection before a person is exposed. Girls who are sexually active should still get the vaccine because it is unlikely they will have been exposed to all of the 4 types of HPV that the vaccine protects against that can cause cervical cancer or genital warts.

### How safe is the vaccine?

The vaccine was shown to be safe during large clinical trials and is used in more than 100 countries. World-wide, over 26 million vaccinations have been given. The vaccine itself cannot cause HPV infection.

### How is the vaccine given?

The vaccine is given as a series of three injections into the upper arm. These injections are given over 6 months at school.

### What happens after each vaccination?

- The public health nurse will observe students for 20 minutes after each vaccination.
- The nurse will give students a form stating where and when the vaccination was given.
- Students may have a sore arm where the vaccination is given. This reaction is expected.

### Other possible reactions include:

- a mild fever (feeling hot)
- redness or swelling at the injection site (hard and sore to touch)
- nausea (feeling sick), vomiting
- dizziness (light headedness), fainting
- headache.

In the unlikely event of a serious allergic reaction, the public health nurse can treat this.

### All women should receive routine 3 yearly cervical smear tests from the age of 20

### What if I change my mind?

If you have given consent and change your mind (before or after any of the three vaccinations) and do not want the vaccinations given at school, you must contact the public health nurse directly. Please **do not** contact the school.

### How private will my consent form be?

The information provided on this consent form is confidential and is protected by the Health Information Privacy Code 1994 and Privacy Act 1993.

Each vaccination will be recorded on the School-based Vaccination System (SBVS) held by district health boards and recorded on the National Immunisation Register (NIR).

### There is more information about privacy on the back page.

### Where can I get more information?

For more information about cervical cancer, HPV and GARDASIL®, phone 0800 IMMUNE (0800 466 863).

### You can also visit these websites:

- HPV Cervical Cancer Vaccine ([www.cervicalcancervaccine.govt.nz](http://www.cervicalcancervaccine.govt.nz))
- Immunisation Advisory Centre ([www.immune.org.nz](http://www.immune.org.nz))
- Medsafe, for information on the safety of the vaccination ([www.medsafe.govt.nz](http://www.medsafe.govt.nz))
- Ministry of Health's immunisation page ([www.moh.govt.nz/immunisation](http://www.moh.govt.nz/immunisation))
- National Immunisation Register ([www.moh.govt.nz/nir](http://www.moh.govt.nz/nir))
- National Screening Unit ([www.nsu.govt.nz](http://www.nsu.govt.nz)).

### Contact the public health nurse directly if you:

- would like more information about filling in this consent form
- are a parent or guardian and would like to be at school when your child receives her vaccinations
- change your mind after giving consent (before or after any of the three vaccinations) and do not want the vaccinations given at school. Please **do not** contact the school.

## CONSENT FORM FOR RECEIVING THE HPV VACCINE

### HOW TO COMPLETE THIS FORM

This consent form is for all three vaccinations.

Students 16 and over and parents or guardians should read the information on pages 1, 2, 3 and 8 before completing this form.

#### Once you have read the information:

- (1) fill in this page (page 4) in **English**
- (2) fill in the **HISTORY** part on the next page (page 5) in **English**
- (3) fill in and sign the **AGREE** or **DO NOT AGREE** part on the next page (page 5) in **English**
- (4) Tear off and return this page and the next (pages 4 and 5) to school. Please keep the other section (pages 1-3) for your information.

Do not fill in pages 6-7. These will be filled in by the public health nurse.

If you want to receive the vaccinations from your family doctor, practice nurse or alternative health provider instead of at school, please complete the **DO NOT AGREE** section and return the form to school.

The information provided on this consent form is confidential and is protected by the Health Information Privacy Code 1994 and Privacy Act 1993.

Contact the public health nurse if you would like help with filling in this form.

School:  Room:

School year:

Student's family name (last name):

Student's first name:

Student's middle name(s):

Other name(s) student is known by:

Date of birth: Day  Month  Year

Home address: Street number  Flat number  Rural number

Street name:

Suburb or rural locality:

Town or city or district:

Phone: Day  Evening  Mobile

With which ethnic group does the student most closely identify? (You may tick more than one.)

NZ European  Maori  Samoan  Cook Islands Maori  Tongan  Niuean  Chinese  Indian

Other (such as Dutch, Japanese, Tokelauan) Please state:

Student's family doctor's name:

Medical centre name:

Medical centre address:

Medical centre phone number:

NHI number, if known:

Tick this box if you do not want the information on this consent form recorded on the National Immunisation Register (NIR). There is more information about the NIR on page 8.

PLEASE FILL OUT AND SIGN PAGES 4 AND 5 AND RETURN TO SCHOOL

### HISTORY

Has the student already received a cervical cancer vaccine?  Yes  No

If you are unsure, ask your family doctor or practice nurse.

If yes:

(1) Please list the date(s) the student has been given the vaccine:

Vaccination 1  Vaccination 2  Vaccination 3

(2) What was the vaccine called? GARDASIL® / Cervarix®

(3) Please name the clinic where the vaccine was given:

### AGREE (CONSENT)

#### IF YOU WANT TO RECEIVE THE VACCINE AT SCHOOL, PLEASE COMPLETE THIS PART OF THE FORM.

Yes,  will have three vaccinations of GARDASIL® at school.

(1) Has the student ever had any serious reaction to any previous vaccinations?  Yes  No

If yes, please describe the reaction:

(2) Does the student have a bleeding disorder or is immune compromised?  Yes  No

If yes, please describe the condition:

(3) Does the student have any other serious medical conditions?  Yes  No

If yes, please describe the condition:

(4) Does the student have any severe allergies to food or medication?  Yes  No

If yes, please describe the allergy:

#### FOR PARENTS OR GUARDIANS

Yes, I agree to all three vaccinations of GARDASIL® being given at school.

Print family or legal guardians' name:

Relationship to student:

Signature:

Date:

#### FOR STUDENTS 16 AND OLDER

Yes, I agree to all three vaccinations of GARDASIL® being given at school.

Print full name:

Date of birth:

Signature:

Date:

### DO NOT AGREE (DO NOT CONSENT)

#### IF YOU DO NOT WANT TO RECEIVE THE VACCINE AT SCHOOL, PLEASE COMPLETE THIS PART OF THE FORM.

#### FOR PARENTS OR GUARDIANS

Students name:

No, I do not agree to the three vaccinations of GARDASIL® being given at school because: (tick one)

She will go to our family doctor or alternative health provider, or

I do not want her to have the vaccinations because: (optional)

Print family or legal guardians' name:

Relationship to student:

Signature:

Date:

#### FOR STUDENTS 16 AND OLDER

Students name:

No, I do not agree to the three vaccinations of GARDASIL® being given at school because: (tick one)

I will go to my family doctor or alternative health provider,

I do not want to have the vaccinations because: (optional)

Date of birth:

Signature:

Date:

PLEASE FILL OUT AND SIGN PAGES 4 AND 5 AND RETURN TO SCHOOL