# GARDASIL® VACCINATION CONSENT

**PATIENT INFORMATION: (Please Print)**

Name ______________________ Date of Birth ______________ Age ________

Address ______________________ Phone Number ______________________

City, State, Zip ______________________ Primary Healthcare Provider ______________________

**MEDICAL INFORMATION:**

| Question | | |
|---|---|---|
| Are you pregnant or planning to get pregnant? | ❑ YES | ❑ NO |
| Have you had an allergic reaction to the vaccine? | ❑ YES | ❑ NO |
| Do you have a bleeding disorder? | ❑ YES | ❑ NO |
| Are you ill, or do you have a fever of more than 100°F? | ❑ YES | ❑ NO |
| Do you have a weakened immune system? | ❑ YES | ❑ NO |

**RISKS AND POSSIBLE SIDE EFFECTS** – As with all vaccines, there may be some side effects with Gardasil®. The most commonly reported side effects may include pain, swelling, itching and redness at the injection site, and fever. Rare side effects may include difficulty breathing. If you experience unusual or severe symptoms after receiving Gardasil®, please contact your health care provider immediately.

***FOR YOUR SAFETY, PLEASE WAIT 10 MINUTES AFTER RECEIVING THE SHOT IN CASE OF ALLERGIC REACTION.***

I understand the benefits and risks of the Gardasil® vaccine and request that it be given to me (or to the person named below for whom I am authorized to make this request). I understand that vaccination with Gardasil® may not result in protection in all vaccine recipients, and that Gardasil® is not intended for use in treatment of active genital warts, cervical cancer, CIN, vulvar intraepithelial neoplasia(VIN), or vaginal intraepithelial neoplasia (VaIN). I hereby assume any risks related to receiving the Gardasil® vaccine, and release the staff of the Huron Clinic from any and all liability related, directly or indirectly, which may arise from having been given the Gardasil® vaccine. I understand that it is recommended to wait at the Clinic for 10 minutes after receiving the shot.

______________________ ______________________ ______________

Signature of Patient (or Legal Guardian) Relation to Patient Date

**MEDICARE / INSURANCE AUTHORIZATION:** I hereby authorize direct payment for all medical benefits to the Huron Clinic for services provided by the clinic and its staff. I hereby authorize the release of all information acquired in the course of my treatment necessary for filing my insurance claims. This authorization will remain in effect until revoked by me in writing. A photocopy of this authorization is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance.

**CREDIT POLICY: Insurance will only be filed upon request.** If you are a Medicaid patient, we will automatically file these claims for you. Payment options are cash, check, or credit card payment (Visa, Mastercard, and Discover). The Clinic will impose a finance charge equal to 1.25% monthly (15% annually) on the unpaid balance on all accounts over ninety (90) days past due. All accounts with an owing balance will receive a monthly statement. If the account is not paid as agreed, the account will be assigned to a collection agency for collection. A $30.00 fee will be added to any check returned due to insufficient funds.

**PRIVACY NOTICE:** In the interest of protecting your private health information, the Huron Clinic complies with the rules and regulations of the Health Insurance Portability & Accountability Act of 1996 (HIPAA). A notice of our privacy practices is posted at the Clinic, and you may obtain a copy upon request.

**FOR CLINIC USE ONLY**

GARDASIL® by Merck & Co., Inc. Lot #_____________ Exp.__________

Date Given ______________________ Nurse Signature ______________________

Injection Site (Deltoid): Left or Right