

*Gardasil is a new vaccine to help prevent infection by certain types of HPV (human papillomavirus) types 6,11,16,18. It is indicated for females 9-26 years of age. These types of HPV can cause:*

*Genital Cervical Warts, Cervical Cancer and or Vaginal Dysplasia*

*Vaccination may not result in protection vaccine recipients. This vaccine is not intended to be used for treatment of active genital warts, cervical cancer, cervical vulvar, or vaginal dysplasia. This vaccine will not protect against every type of HPV; it will not protect against other sexually transmitted diseases. As with all injectable vaccines, patients may have a rare anaphylactic reaction that can be life threatening. This vaccine is not recommended for use during pregnancy.*

*There is a fee of \$175.00 per injection, and full payment is required at the time of each vaccination. I understand the vaccine will be given in a series of 3 injections. The first injection will be given at the initial visit, the second in 2 months, and the 3<sup>rd</sup> in 6 months after the 1<sup>st</sup> dose. A booster shot may be necessary in the future.*

*My signature below acknowledges that I have agreed to undergo the series of 3 injections and that I am aware of my financial obligations.*

*I am aware that I am not within the age range that has been recommended to undergo the Gardasil vaccine, but I am requesting the series of vaccinations* \_\_\_\_\_

*Initials*

*I do want the Gardasil Vaccine* \_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Date*

*I do NOT want the Gardasil Vaccine* \_\_\_\_\_  
*Patient Signature*

\_\_\_\_\_  
*Date*

*Vaccine Lot #*

*Injection Site*

*Signature*

1. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_

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