Human Papillomavirus (HPV) Vaccination Guide and Consent Form

(For those between the ages of 13-15 years old who are not accompanied by a parent or guardian)

- **Parents and guardians, please ensure to read this document.**

Until now, children have always required the accompaniment of a parent or guardian when receiving a vaccination. However, children aged 13 years or older can receive the HPV vaccination without parental supervision, providing their parent or guardian has thoroughly read and understood this guide, and signed the consent form and pre-vaccination medical questionnaire on the reverse of this document permitting their child to be vaccinated. Please make sure your child brings this document and the pre-vaccination medical questionnaire on the day of vaccination.

Please only sign the consent form and pre-vaccination medical questionnaire once you have dispelled any doubts or concerns you may have regarding the receipt of the HPV vaccination by consulting your physician or local Health Promotion Division or Public Health Promotion Division in advance, and fully understand the benefits and risks of vaccination.

1 Symptoms of HPV infection

The human papillomavirus infects the skin and mucus membranes of the human body and over 200 different types have been identified to date. Amongst these, the types that mainly infect mucus membranes enter the body through small superficial cuts caused during sexual intercourse and invade the genital mucus membranes. It is estimated that more than 50% of sexually active women abroad will be infected by these viruses at least once in their life.

Amongst the different strains of HPV which infect mucus membranes, at least 15 types are detected in cervical cancers and are referred to as "high-risk HPV types". Types 16 and 18 are particularly high-risk with a high frequency rate and studies indicate that these two viruses are involved in about 70% of cervical cancer incidences abroad. In addition to cervical cancer, at least 90% of anal cancer and 40% of vaginal, vulvar, and penile cancer incidences detected abroad are suspected to be connected with these two strains. Viruses not classified into high-risk categories are confirmed to cause benign anogenital warts (condyloma acuminatum).

2 Benefits and side effects of vaccination

The vaccine includes viral components of several types of HPVs and vaccinated children will acquire immunity to these viruses, subsequently protecting from HPV infections.

However, vaccination occasionally causes mild side effects, and very rarely may cause serious side effects.

Main side effects of the HPV vaccine

(1) Common side effects which are considered to be related to the vaccine are listed below.

Frequency of Incidence	Cervarix® Bivalent Vaccine	GARDASIL® Quadrivalent Vaccine	SILGARD®9 Nonavalent Vaccine
50% or more	Pain, redness, swelling, fatigue	Pain	Pain
10～49%	Itchiness, abdominal pain, muscle pain, joint pain, headaches	Erythema, swelling	Swelling, erythema, headaches
1～9%	Rash, dizziness, fever	Headaches, itchiness, fever	Dizziness, nausea, diarrhea, itchiness, fever, fatigue, internal bleeding
Less than 1%	Abnormal sensations at the site	Diarrhea, abdominal pain, limb	Nausea, stomach pain,

	of injection, numbness, weakness throughout body	pain, musculoskeletal pain, skin hardening, bleeding, feelings of discomfort, fatigue	muscle pain, Joint pain, bleeding, hematoma, fatigue, skin hardening
Frequency Unknown	Limb pain, fainting, inflammation of lymph nodes	Fainting, nausea, joint pain, muscle ache, fatigue	Numbness, fainting, limb pain

(2) In rare instances, one may experience a hypersensitive reactions; such as an anaphylactic reaction, or anaphylaxis- like reaction (difficulty breathing, swelling around the eyes or lips, tracheal spasm (episodic shortness of breath), rash), Guillain-Barre Syndrome (ascending paralysis of both legs), immune thrombocytopenic purpura (ITP) (purple spots, nose bleeds, bleeding of the gums), or acute disseminated encephalomyelitis (ADEM) (paralysis, sensory impairment, motor impairment). If you experience any of the above, please consult with your physician immediately.

3 Compensatory System for those Experiencing Health Complications related to Vaccination

(1) Those who experience health complications that require medical treatment or develop an impairment affecting their daily life as a result of a routine vaccination can be compensated under the Preventive Vaccination Act.

(2) Depending on the severity of the health complications experienced, compensation under law is provided for medical expenses, medical allowance, child-rearing pension for disabled children, disability pension, lump-sum death benefit, funeral expenses, and caregiving allowance. Apart from lump-sum death benefits and funeral expenses, these benefits will be paid until the conclusion of treatment for the illness or the period of treatment in the case of impairment.

(3) However, to receive compensation, a national review committee composed of experts in fields such as vaccination and the treatment of infectious diseases, as well as legal experts, must determine if the health complications are experienced as a direct result of vaccination or if there are other attributing factors (such as infection contracted prior or following vaccination). If it can be proven that the health complications were caused by vaccinations, then you will be eligible to receive compensation.

※For queries regarding compensation applications, please contact the Public Health Promotion Division （053-453-6119）.

4 Cautions for Vaccination

Vaccination are generally administered to a child in good health. If your child is unwell, please consult your physician and decide whether your child should be vaccinated.

If your child is experiencing any of the following, they cannot receive a vaccination:

(1) Those with an obvious fever (of 37.5℃ or above).
(2) Those suffering from a severe acute disease.
(3) Those with a history of hypersensitivity to vaccine ingredients.
(4) Those who have been advised by a physician to not receive the vaccination.

We ask those who are currently pregnant to consult their physician regarding the best course of action.

○ Parents and guardians, please ensure to read the following

Please only decide to vaccinate your child after carefully reading and fully understanding the content written above. If you decide on vaccination, please sign the consent form and pre-vaccination medical questionnaire below and select your desired vaccine.

Without your signature, your child is not permitted to be vaccinated.

Consent Form

I confirm that I consent to having my child vaccinated after having read the explanation regarding the vaccination against human papilloma virus (HPV) infection and understanding the benefits and risks of serious side effects of the vaccine, as well as the compensatory system for those experiencing any health complications caused by the vaccine.

I understand that this document has been created with the express purpose to aid parents' and guardians' understanding of vaccinations and consent to this form being submitted to Hamamatsu City.

Signature of Parent/Guardian :

Address :

Emergency contact number :

Desired vaccine SILGARD®9 ・ GARDASIL® ・ Cervarix® :

※Please circle your desired vaccination.

* Submission of this form is necessary for your unaccompanied child to be vaccinated against HPV infection. If your child is aged between 13-15 years and receiving the vaccine unaccompanied, please ensure they submit this form and the pre-vaccination medical questionnaire to the medical facility.

If this form and the pre-vaccination medical questionnaire are not signed by the parent or guardian, then the child will not be able to receive the vaccine unaccompanied.

ヒトパピローマウイルス感染症予防接種予診票兼接種・非接種通知書
（受ける人が13歳から15歳で保護者が同伴しない場合）

Vaccine Screening Questionnaire for Human Papilloma Virus Infection

(For the use if the child is NOT accompanied by the guardian)

Please fill in the blanks and circle the appropriate answer
(Especially the blanks in bold frames)

種類	シルガード9	ガーダシル	サーバリックス
	24	23	22

回数	1回目	2回目	3回目
	1	2	3

Immunization Date 申込年月日	Year年 Month月 Day日			
Address 住所	Hamamatsu-shi		Temperature 診察前の体温	℃
			Telephone 電話	
フリガナ				
Name of the child 受ける人の氏名		Gender 性別 F 女	Birth Date 生年月日	year 年 month 月 day 日
			Age 年齢	years & months old

Questions	*Answers*		*Dr. Use*
Did you read and undestand the explanation about the vaccination to be administered today? 今日受ける予防接種についての説明書を読み、理解しましたか	No	Yes	
Does the patient have any concerns about the child's health today? 今日体に具合の悪いところがありますか If yes, describe the symptoms : 具体的な症状を書いてください ( )	Yes	No	
Has the patient been ill within this past month? 最近1ヵ月以内に病気にかかりましたか If yes, describe the illness 病名 ( )	Yes	No	
Has the patient received any immunization within the past month? (If yes, describe the date and circle the type) 最近1ヵ月以内に予防接種を 受けましたか(受けた場合には最後に接種した年月日とワクチンの種類に〇を記入してください) Date 接種年月日 year年 month月 day 日 ・Japanese encephalitis日本脳炎 ・Diphteria / Tetanus DT ・Cervical cancer vaccine子宮頸がん予防 ・Others その他 ( )	Yes	No	
Has the patient ever taken a vaccination of other Human Papilloma Virus Infection? これまでにヒトパピローマウイルス感染症予防接種を受けたことがありますか	Yes	No	種類・間隔
ある場合は接種したワクチンに〇をして接種年月日を記載してください 1回目 (シルガード9・ガーダシル・サーバリックス) 年 月 日 2回目 (シルガード9・ガーダシル・サーバリックス) 年 月 日			
Has the patient ever been treating of congenital abnormalities(diseases of heart,renal,liver,neurologic, immunodeficiency or other serious disease)from birth to now? Is the child consulting any physician now? 生まれてから今までに先天性異常、心臓、腎臓、肝臓、脳神経、免疫不全症、その他の病気にかかり、医師の診察を受けていますか If yes, describe the illness 病名 ( )	Yes	No	
Did the doctor in charge for the treatment approved the immunization today? その病気を診てもらっている医師に今日の予防接種を受けてよいといわれましたか	No	Yes	
Has the patient ever had convulsions? ひきつけ(けいれん)を起こしたことがありますか If yes, at what age? ( ) 歳頃	Yes	No	
Did the patient have a fever at the time? そのときに熱が出ましたか	Yes	No	
Has the patient ever had skin rash or felt ill after taking any medicine or food? 薬や食品、ゴム製品、金属などで皮膚に発疹やじんましんが出たり、体の具合が悪くなったことがありますか If yes, what kind of medicine or food 薬・食品・製品名など (	Yes	No	
Is there any close relatives with congenital immunodeficiency? 近親者に先天性免疫不全と診断されている方はいますか	Yes	No	
Has the patient ever felt ill after receiving a vaccination? これまでに予防接種を受けて具合が悪くなったことはありますか If yes, what type of vaccine? 予防接種の種類 ( )	Yes	No	
Has any of your close relatives ever felt ill after receiving a vaccination? 近親者に接種を受けて具合が悪くなった人はいますか	Yes	No	
For women: is there any possibility the patient might be pregnant (ex.: delayed period, etc.)? 女性の方へ:現在妊娠している可能性(生理が予定より遅れているなど)はありますか(注)妊娠または妊娠している可能性のある方への接種はのぞましくありません	Yes	No	
Do you have any questions regarding today's vaccination? 今日の予防接種について質問がありますか	Yes	No	

医師の記入欄 Doctor's Use			
以上の問診及び診察の結果、今日の予防接種は According to the result , today's vaccination is:	**3 可能 Possible**	**2 見合わせる Postponed**	医師のサイン *Physician's signature*
接種を受ける本人に対して、予防接種の効果、副反応及び予防接種健康被害救済制度について、説明をしました。			**(注)ワクチンの種類・有効期限を要確認**

Having received the doctor's examination and explanation and having understood the aims and effects of this immunization, the risk of severe side effects and the vaccine injury compensation program, do you consent the immunization?	**Yes** 同意します	**No** 同意しません	*Guardian's signature* 保護者自署
This questionnaire has the purpose to ensure the immunization's safety. I'm aware of that and agree with the submission of this questionnaire to the Hamamatsu city.			

使用ワクチン	接種量	実施場所 ・ 医師名 ・ 接種年月日
ワクチン名 Lot No. **(注)有効期限が切れていないか要確認**	(筋肉内接種) 0.5 mL	実施場所 医師名 接種年月日(非接種判定日) 年 月 日