Please fill form in **BLOCK** capitals \* indicates section is **mandatory** and must be completed

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient’s details | | | | | | | | | | |
| **FIRST NAME\*** |  | | | | | | | | | |
| **SURNAME\*** |  | | | | | | | | | |
| POSTCODE |  | | | | | | | | | |
| **NHS Number** |  | | | | | | | | | |
| **DATE OF BIRTH\*** |  |  |  |  |  |  |  |  |  | Sex: ⧠ Male ⧠ Female ⧠ Not Stated |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Clinical Screening | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **REASON ELIGIBLE FOR**  **COVID VACCINE TODAY\*** | Lives in a care home  A health care worker  A social worker  Over 65 years old  Pregnant  Immunosuppressed  Clinically at risk (eg asthma, heart disease, diabetes)  Homeless or living in supported living accomodation  Carer  Had CAR-T therapy or stem cell transplantation since last vaccine | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CAUTION CHECKLIST\*** | 1. Are you currently unwell with a fever or have covid symptoms? 2. Have you had the shingles vaccine in the last 7 days? 3. Have you had anaphylaxis (serious allergy requiring adrenaline injection), a reaction to a previous covid vaccine, or significant unexplained allergies? 4. Have you been previously diagnosed with covid vaccine related myocarditis or pericarditis? 5. Do you have a history of capillary leak syndrome? 6. Do you have a history of idiopathic thrombocytopenia (ITP)? | | | | | | | | | | | | | | | | | | | | | | ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes | | | ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No | |
|  | 1. Do you take anticoagulation medication (such as warfarin, apixaban, dabigatran) or have a bleeding disorder? This does not include aspirin. | | | | | | | | | | | | | | | | | | | | | | ⧠ Yes | | | ⧠ No | |
| Consent | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Consent\*** | **Do you give consent to receive the vaccine?** | | | | | | | | | | | | | | | | | | **⧠ Yes** | | | | | **⧠ No** | | | |
| Consent provided by\* | ⧠ Patient ⧠ Parent ⧠ Healthcare Lasting Power of Attorney ⧠ Court Appointed Deputy  ⧠ Clinician using Best Interests process of Mental Capacity Act | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If consent was **not** obtained by the Patient, then please complete the below fields: | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Individual Consulted | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | | |  | |  |
| Authorising Clinician | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | | |  | |  |

|  |  |  |
| --- | --- | --- |
| Vaccination - OFFICIAL USE ONLY | | |
| Name/Initials Vaccinator |  | **Flu given:** **⧠ Yes ⧠ No** |
| Date/Time of vaccination |  |
| Site of COVID administration | ⧠ Left deltoid  ⧠ Right deltoid |