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

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| --- |
| 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 homeA health care workerA social workerOver 65 years oldPregnant ImmunosuppressedClinically at risk (eg asthma, heart disease, diabetes)Homeless or living in supported living accomodationCarerHad 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 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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