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 |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Clinical Screening | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **ELIGIBILITY FOR**  **COVID VACCINE TODAY** | Lives in a care home  Over 75  Immunocompromised | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | Are you severely immunocompromised? | | | | | | | | | | | | | | | | | | | | | | ⧠ Yes | | | ⧠ No | |
|  | Are you or could you be pregnant? | | | | | | | | | | | | | | | | | | | | | | ⧠ Yes | | | ⧠ No | |
| **CAUTION CHECKLIST\*** | 1. Do you have a history of anaphylaxis or significant allergic reactions to any vaccines or its ingredients? 2. Have you experienced any serious adverse reactions after previous covid-19 vaccine doses? | | | | | | | | | | | | | | | | | | | | | | ⧠ Yes  ⧠ Yes | | | ⧠ No  ⧠ 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 |  |  |
| Date/Time of vaccination |  |
| Site of COVID administration | ⧠ Left deltoid  ⧠ Right deltoid |