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 |
| **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 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| --- |
| Vaccination - OFFICIAL USE ONLY |
| Name/Initials Vaccinator |  |  |
| Date/Time of vaccination |  |
| Site of COVID administration | ⧠ Left deltoid ⧠ Right deltoid  |