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| SECTION 1 - Patient’s details (ALL PATIENTS MUST COMPLETE) | | | | | | | | | | |
| **FIRST NAME** |  | | | | | | | | | |
| **SURNAME** |  | | | | | | | | | |
| **POSTCODE** |  | | | | | | | | | |
| **NHS Number** |  | | | | | | | | | |
| **DATE OF BIRTH** |  |  |  |  |  |  |  |  |  | ⧠ Male  ⧠ Female ⧠ N/A |

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| **TICK WHICH VACCINES YOU ARE HAVING TODAY**  **COVID BOOSTER**  **FLU**  **\*\*\*IF HAVING FLU VACCINATION ONLY, PLEASE GO STRAIGHT TO SECTION 3 TO SIGN CONSENT\*\*\*** |

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| SECTION 2 - Clinical Screening (COVID BOOSTERS ONLY) | | | | | |
| **REASON ELIGIBLE FOR**  **COVID VACCINE TODAY**  (ONLY COMPLETE IF HAVING COVID BOOSTER) | Works in a care home  A health care worker  A social worker  Age  Pregnant  Immunosuppressed Household contact for immunosuppresed  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 | | | | |
| **VACCINE SEQUENCE** | 1st Vaccination 2nd Vaccination Booster | | | | |
| **CAUTION CHECKLIST**  (ONLY COMPLETE IF HAVING COVID BOOSTER) | 1. Are you severely immunosuppressed? 2. Have you tested positive for covid in the last 4 weeks? 3. Are you currently unwell with a fever or have covid symptoms? 4. Have you had the shingles vaccine in the last 7 days? 5. Have you had anaphylaxis (serious allergy requiring adrenaline injection), a reaction to a previous covid vaccine, or significant unexplained allergies? 6. Have you been previously diagnosed with covid vaccine related myocarditis or pericarditis? 7. Do you have a history of capillary leak syndrome? 8. Do you have a history of idiopathic thrombocytopenia (ITP)? 9. Have you/are you in a trial of a potential coronavirus vaccine? | | ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes | | ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No |
| (ONLY COMPLETE IF HAVING COVID BOOSTER) | 1. Do you take anticoagulation medication (such as warfarin, apixaban, dabigatran) or have a bleeding disorder? This does not include aspirin. | | ⧠ Yes | | ⧠ No |
| SECTION 3 – Consent (ALL PATIENTS MUST COMPLETE) | | | | | |
| **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 | | | | |

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