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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 homeA health care workerA social workerAgePregnant Immunosuppressed Household contact for immunosuppresed Clinically at risk (eg asthma, heart disease, diabetes)Homeless or living in supported living accomodationCarerHad 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  |