Classification: Official

Rural West PCN COVID-19 Vaccination Record form Spring 25

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

REASON ELIGIBLE FOR COVID VACCINE TODAY*

- ☐ Lives in a care home
- ☐ Over 75 years old
- ☐ Immunosuppressed
- ☐ Home Visit

CAUTION CHECKLIST*

1. Are you currently unwell with a fever or have covid symptoms?	☐ Yes	☐ No
2. Have you had the shingles vaccine in the last 7 days?	☐ Yes	☐ No
3. Have you had anaphylaxis (serious allergy requiring adrenaline injection), a reaction to a previous covid vaccine, or significant unexplained allergies?	☐ Yes	☐ No
4. Have you been previously diagnosed with covid vaccine related myocarditis or pericarditis?	☐ Yes	☐ No
5. Do you have a history of capillary leak syndrome?	☐ Yes	☐ No
6. Do you have a history of idiopathic thrombocytopenia (ITP)?	☐ Yes	☐ No
7. 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	

Vaccination - OFFICIAL USE ONLY

Name/Initials Vaccinator		
Date/Time of vaccination		
Site of COVID administration	☐ Left deltoid ☐ Right deltoid	