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** | Live in a care home  Over 75 years old  Immunosuppressed | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **RECENT COVID** | Have you had any covid symptoms or tested positive in the last 4 weeks? ⧠ Yes ⧠ No | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **CAUTION CHECKLIST\*** | 1. Are you currently unwell with a fever or have covid symptoms? 2. Have you had the shingles vaccine in the last 7 days 3. Have you had anaphylaxis (serious allergy requiring adrenaline injection), a reaction to a previous covid vaccine, or significant unexplained allergies? 4. Have you been previously diagnosed with covid vaccine related myocarditis or pericarditis? 5. Do you have a history of capillary leak syndrome? 6. Do you have a history of idiopathic thrombocytopenia (ITP)? | | | | | | | | | | | | | | | | | | | | | | ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes | | | ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No | |
|  | 1. Do you take anticoagulation medication such as warfarin, apixaban, dabigatran or have a bleeding disorder? This does not include aspirin. | | | | | | | | | | | | | | | | | | | | | | ⧠ Yes | | | ⧠ No | |
| **SANOFI ONLY** | 1. **VidPrevtyn Beta vaccine (Sanofi) contains squalene, an ingredient derived from fish oil. Do you have any religious, ethical or medical reasons why you cannot have this vaccine?** | | | | | | | | | | | | | | | | | | | | | | ⧠ 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 | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | | |  | |  |

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