

COVID-19 Vaccination Service – Record form

Please fill form in **BLOCK** capitals

* indicates section is mandatory and must be completed

Patient's details																			
First name*																			
Surname*																			
Address*																			
Postcode*																			
Date of birth*			/			/													
Sex*	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not Stated																		
NHS No.																			
GP Practice*																			
Address*																			

Clinical Screening			
Exclusion Checklist*	1. Have you had any vaccination in the last seven days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	2. Are you currently unwell with fever?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	3. Have you ever had any serious allergic reaction to any ingredients of the Covid-19 vaccines, drug or other vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	4. Have you ever had an unexplained anaphylaxis reaction?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Caution Checklist*	5. Are you, or could you be pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	6. Are you or have you been in a trial of a potential coronavirus vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	7. Are you taking anticoagulant medication, or do you have a bleeding disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	8. Do you currently have any symptoms of Covid-19 infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Consent			
Consent*	Do you give consent to receive the vaccine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Consent provided by*	<input type="checkbox"/> Patient <input type="checkbox"/> Healthcare Lasting Power of Attorney <input type="checkbox"/> Court Appointed Deputy <input type="checkbox"/> 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			
Registration Number			
Notes			

Outcome	
Outcome*	<input type="checkbox"/> Continue with vaccine administration <input type="checkbox"/> Vaccination not given (see additional section below)

Pre-screening Clinician																		
First name*																		
Surname*																		
Professional body registration no.*																		
Signature*																		

Vaccination details												
Date of vaccination*			/				/					DD/MMM/YYYY – 01/JAN/2000
Time of vaccination*			:									HH:MM – 17:56
Dose Sequence*	<input type="checkbox"/> First Administration <input type="checkbox"/> Second Administration											
Name of Vaccine*	<input type="checkbox"/> COVID-19 mRNA Vaccine BNT162b2 30micrograms/0.3ml dose concentrate for suspension for injection multidose vials (Pfizer-BioNTech) <input type="checkbox"/> COVID-19 Vaccine AstraZeneca (ChAdOx1 S [recombinant]) 5x10,000,000,000 viral particles/0.5ml dose solution for injection multidose vials <input type="checkbox"/> 8 dose vial <input type="checkbox"/> 10 dose vial											
Batch Number*												
Manufacturer's expiry date*			/			/						DD/MMM/YYYY – 01/JAN/2000
Use by date*			/			/						DD/MMM/YYYY – 01/JAN/2000
Administration Site*	<input type="checkbox"/> Left deltoid <input type="checkbox"/> Right deltoid <input type="checkbox"/> Left thigh <input type="checkbox"/> Right thigh											
Route of administration*	<input type="checkbox"/> Intramuscular											
Any adverse effects*	<input type="checkbox"/> None Observed <input type="checkbox"/> Yes (please note details in notes section below)											

Vaccine not given	
Dose sequence not given	<input type="checkbox"/> First Administration <input type="checkbox"/> Second Administration
Reason vaccine not administered	<input type="checkbox"/> Generally feeling unwell / Symptomatic <input type="checkbox"/> Contraindications / Clinically not suitable <input type="checkbox"/> Consent not given

Notes	
Clinical notes e.g. adverse reactions	

Vaccinator												
First name*												
Surname*												
Professional body registration no.*												
Signature*												

Vaccine Drawer												
First name*												
Surname*												
Professional body registration no.*												
Signature*												

For Care Home use only												
Name of Care Home												
Patient Category	<input type="checkbox"/> Member of Staff <input type="checkbox"/> Care Home Resident											