COVID-19 Vaccination Service – Record form

**Version 3.0**

Please fill form in **BLOCK** capitals

\* indicates section is mandatory and must be completed

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| Patient’s details | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First name\* |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Surname\* |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Address\* |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Postcode\* |  |  |  |  |  |  |  |  |  | | | | | | | | | | | | | | | | | | |
| Date of birth\* |  |  | / |  |  |  | / |  |  |  | |  | DD/MMM/YYYY – 01/JAN/2000 | | | | | | | | | | | | | | | |
| Sex\* | ⧠ Male ⧠ Female ⧠ Not Stated | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NHS No. |  |  |  |  |  |  |  |  |  | |  |  |  |  | | | | | | | | | | | | | |
| GP Practice\*  Address\* |  |  |  |  |  |  |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Clinical Screening | | | |
| Screening Questions\* | 1. Are you currently unwell with fever? 2. Have you ever had any serious allergic reaction? 3. Have you ever been prescribed an adrenaline autoinjector such as EpiPen? 4. Are you or have you been in a trial of a potential coronavirus vaccine? 5. Are you, or could you be pregnant, breastfeeding or planning to become pregnant in the next three months? 6. Are you taking anticoagulant medication, or do you have a bleeding disorder? 7. Have you had any vaccinations in the last seven days? | ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes  ⧠ Yes | ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No  ⧠ No |

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| Consent | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Consent\* | Do you give consent to receive the vaccine? | | | | | | | | | | | | | | | | | | | | | ⧠ Yes | | | | ⧠ No | | |
| Consent provided by\* | ⧠ Patient  ⧠ 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 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | |  |  |
| Registration Number |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  |  | |  |  |
| Notes |  | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| Outcome | |
| Outcome\* | ⧠ Continue with vaccine administration  ⧠ Vaccination not given (see additional section below) |

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

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| Vaccination details | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of vaccination\* |  |  | / | |  | |  | |  | | / | |  | |  |  | |  | | DD/MMM/YYYY – 01/JAN/2000 | | | | | | | | | | | | | | |
| Time of vaccination\* |  |  | : | |  | |  | | MM:HH | | | | | | | | | | | | | | | | | | | | | | | | |
| Dose Sequence | ⧠ First Administration  ⧠ Second Administration | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of Vaccine | ⧠ COVID-19 mRNA Vaccine BNT162b2 30micrograms/0.3ml dose concentrate for suspension for injection multidose vials (Pfizer-BioNTech) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Batch Number |  |  | |  | |  | |  | |  | |  | |  |  | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Manufacturer’s expiry date\* |  |  | | / | |  | |  | |  | | / | |  |  | |  | |  | | DD/MMM/YYYY – 01/JAN/2000 | | | | | | | | | | | | |
| Use by date\* |  |  | | / | |  | |  | |  | | / | |  |  | |  | |  | | DD/MMM/YYYY – 01/JAN/2000 | | | | | | | | | | | | |
| Administration Site\* | ⧠ Left deltoid  ⧠ Right deltoid  ⧠ Left thigh  ⧠ Right thigh | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Route of administration\* | ⧠ Intramuscular | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Any adverse effects\* | ⧠ None Observed  ⧠ Yes (please state): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Any advice given and any other notes |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| Vaccine not given | |
| Dose sequence not given | ⧠ First Administration  ⧠ Second Administration |
| Reason vaccine not administered | ⧠ Generally feeling unwell / Symptomatic  ⧠ Contraindications / Clinically not suitable  ⧠ Consent not given |

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

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

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| Notes | |
| Clinical notes  e.g. adverse reactions |  |