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*	/ / DD/MMM/YYYY – 01/JAN/2000
Sex*	☐ Male ☐ Female ☐ Not Stated
NHS No.	
GP Practice* Address*	

Clinical Screening			
Screening Questions*	1. Are you currently unwell with fever?	☐ Yes	☐ No
	2. Have you ever had any serious allergic reaction?	☐ Yes	☐ No
	3. Have you ever been prescribed an adrenaline autoinjector such as EpiPen?	☐ Yes	☐ No
	4. Are you or have you been in a trial of a potential coronavirus vaccine?	☐ Yes	☐ No
	5. Are you, or could you be pregnant, breastfeeding or planning to become pregnant in the next three months?	☐ Yes	☐ No
	6. Are you taking anticoagulant medication, or do you have a bleeding disorder?	☐ Yes	☐ No
	7. Have you had any vaccinations in the last seven days?	☐ Yes	☐ No

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			

Outcome	
Outcome*	☐ Continue with vaccine administration ☐ 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*	: 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	

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

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

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

Notes	
Clinical notes e.g. adverse reactions	