Classification: Official

Rural West PCN COVID-19 Vaccination Record form Spring 24

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

ELIGIBILITY FOR COVID VACCINE TODAY	☐ Over 75 ☐ Lives in a care home ☐ Immunocompromised		
	Are you severely immunocompromised?	☐ Yes	☐ No
	Are you or could you be pregnant?	☐ Yes	☐ No
CAUTION CHECKLIST*	1. Do you have a history of anaphylaxis or significant allergic reactions to any vaccines or its ingredients? 2. Have you experienced any serious adverse reactions after previous covid-19 vaccine doses?	☐ Yes ☐ Yes	☐ No ☐ 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		☐ Housebound
Date/Time of vaccination		
Site of COVID administration	☐ Left deltoid ☐ Right deltoid	