

COVID-19 - Offline vaccination record form

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| Patient’s details | | |
| First name | **Malcolm**  **Railson**  21 Under The Stairs  NN5 6TW  The Crescent Medical Centre | Appointment: 9-Jan-21 at 09:06 am  DOB:  \*04-JUN-1975\*  Sex: Male  NHS Number:  \*6303598156\* |
| Surname |
| Address |
| Postcode |
| GP Practice |

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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 | ⧠ No  ⧠ No  ⧠ No |
|  | ⧠ Yes | ⧠ No |
|  | ⧠ Yes | ⧠ No |
|  | ⧠ Yes | ⧠ No |
|  | ⧠ 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  ⧠ Independent Mental Capacity Advocate (IMCA)  ⧠ Clinician using Best Interests process of Mental Capacity Act | | |

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

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| Date of First Vaccination |  | | | | | | **Vaccine given by:** |
| Time of vaccination\* |  |  | : |  |  | MM:HH **Vaccine drawn by:** | |
| Dose Sequence | ⧠ First Administration  ⧠ Second Administration | | | | | | |

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| --- | --- |
| Administration Site | ⧠ Left deltoid  ⧠ Right deltoid  ⧠ Left thigh  ⧠ Right thigh |
| Route of administration | ⧠ Intramuscular |
| Date of Second Vaccination: |  |

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| Vaccination details | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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/MM/YY | | | | | | | | | | | | | | | | |
| Use by date\* |  |  | / |  |  | / |  |  | DD/MM/YY | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Any adverse effects\* | ⧠ None Observed  ⧠ Yes (please state): | | | | | | | | | | | | | | | | | | | | | | | | | |
| Any advice given and any other notes |  | | | | | | | | | | | | | | | | | | | | | | | | | |

A picture containing text

Description automatically generated

Timeline

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

COVID-19 Offline vaccination record form (adapted) 2