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			
Exclusion Checklist*	1. Have you had any vaccination in the last seven days?	☐ Yes	☐ No
	2. Are you currently unwell with fever?	☐ Yes	☐ No
	3. Have you ever had any serious allergic reaction to any ingredients of the Covid-19 vaccines, drug or other vaccine?	☐ Yes	☐ No
	4. Have you ever had an unexplained anaphylaxis reaction?	☐ Yes	☐ No
Caution Checklist*	5. Are you, or could you be pregnant?	☐ Yes	☐ No
	6. Are you or have you been in a trial of a potential coronavirus vaccine?	☐ Yes	☐ No
	7. Are you taking anticoagulant medication, or do you have a bleeding disorder?	☐ Yes	☐ No
	8. Do you currently have any symptoms of Covid-19 infection?	☐ 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*	: HH:MM – 17:56
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) ☐ COVID-19 Vaccine AstraZeneca (ChAdOx1 S [recombinant]) 5x10,000,000,000 viral particles/0.5ml dose solution for injection multidose vials ☐ 8 dose vial ☐ 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*	☐ Left deltoid ☐ Right deltoid ☐ Left thigh ☐ Right thigh
Route of administration*	☐ Intramuscular
Any adverse effects*	☐ None Observed ☐ Yes (please note details in notes section below)

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

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	☐ Member of Staff ☐ Care Home Resident