

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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not Stated
Clinical Screening													
ELIGIBILITY FOR COVID VACCINE TODAY	<input type="checkbox"/> Over 75 <input type="checkbox"/> Lives in a care home <input type="checkbox"/> Immunocompromised												
	Are you severely immunocompromised?										<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	Are you or could you be pregnant?										<input type="checkbox"/> Yes	<input type="checkbox"/> No	
CAUTION CHECKLIST*	1. Do you have a history of anaphylaxis or significant allergic reactions to any vaccines or its ingredients? <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Have you experienced any serious adverse reactions after previous covid-19 vaccine doses? <input type="checkbox"/> Yes <input type="checkbox"/> No										<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Consent													
Consent*	Do you give consent to receive the vaccine?										<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Consent provided by*	<input type="checkbox"/> Patient <input type="checkbox"/> Parent <input type="checkbox"/> Healthcare Lasting Power of Attorney <input type="checkbox"/> Court Appointed Deputy <input type="checkbox"/> 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											<input type="checkbox"/> Housebound		
Date/Time of vaccination													
Site of COVID administration	<input type="checkbox"/> Left deltoid <input type="checkbox"/> Right deltoid												