Classification: Official

Rural West PCN COVID-19 Vaccination Record form Spring 23

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	☐ Live in a care home ☐ Over 75 years old ☐ Immunosuppressed		
RECENT COVID	Have you had any covid symptoms or tested positive in the last 4 weeks?	☐ Yes	☐ No
CAUTION CHECKLIST*	1. Are you currently unwell with a fever or have covid symptoms?	☐ Yes	☐ No
	2. Have you had the shingles vaccine in the last 7 days	☐ Yes	☐ No
	3. Have you had anaphylaxis (serious allergy requiring adrenaline injection), a reaction to a previous covid vaccine, or significant unexplained allergies?	☐ Yes	☐ No
	4. Have you been previously diagnosed with covid <u>vaccine</u> related myocarditis or pericarditis?	☐ Yes ☐ Yes	☐ No ☐ No
	5. Do you have a history of capillary leak syndrome?	☐ Yes	☐ No
	6. Do you have a history of idiopathic thrombocytopenia (ITP)?		
	7. Do you take anticoagulation medication such as warfarin, apixaban, dabigatran or have a bleeding disorder? This <u>does not</u> include aspirin.	☐ Yes	☐ No
SANOFI ONLY	**8. VidPrevtyn Beta vaccine (Sanofi) contains <u>squalene</u>, an ingredient derived from <u>fish oil</u>. Do you have any religious, ethical or medical reasons why you cannot have this vaccine?**	☐ Yes	☐ 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	
Date/Time of vaccination	
Site of COVID administration	☐ Left deltoid ☐ Right deltoid