|  |  |  |  |
| --- | --- | --- | --- |
| First name: |  | Surname: |  |
| Date of Birth: |  | Telephone Number: |  |
| GP Surgery: |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Vaccine |  | Time of vaccine: |  |
| Astra Zeneca | Pfizer |  |  |
| Batch Number: | Expiry Date: | Use by date: |  |
| LeftDeltoid | RightDeltoid | Left Thigh | Rightthigh |
| Intramuscular | FirstVaccine | Second vaccine |

|  |  |
| --- | --- |
| Dose sequence not given | ⧠ First Administration ⧠ Second Administration |
| Reason vaccine not administered | ⧠ Generally feeling unwell / Symptomatic⧠ Contraindications / Clinically not suitable⧠ Consent not given |
| Vaccinator |  |
| Drawer |  |

|  |  |
| --- | --- |
| Are you a Carer?  | Ethnicity  |
| ⧠ Are you a Carer?⧠Are you a social care worker?⧠ Are you a healthcare worker?⧠ Do you work in residential care home?⧠Do you live in residential care home?⧠None of the above ⧠ Refused to answerEvidence shown ……………………………………..(ie. name badge / smart card / payslip) | ⧠ White British ⧠White Irish ⧠ White other⧠ Mixed - White and Black Caribbean⧠ Mixed - White and Asian ⧠ Mixed - Other mixed⧠ Asian or Asian British – Indian ⧠ Asian or Asian British – Pakistani ⧠ Asian or Asian British – Bangladeshi⧠ Asian or Asian British - Other Asian Background⧠ Black or Black British – Caribbean⧠ Black or Black British – African⧠ Black or Black British – Other⧠Chinese⧠ Any other ethnic group ⧠ Not stated/Given  |

 CONSENT

|  |  |  |  |
| --- | --- | --- | --- |
| First name: |  | Surname: |  |
| Home Address: |  | Postcode: |  |
| Date of Birth: |  | Telephone Number: |  |
| GP Surgery: |  | NHS Number: |  |

|  |  |  |
| --- | --- | --- |
| Are you under 16 years of age? | YES | NO |
| Do you currently have a severe illness with a high temperature? | YES | NO |
| Have you ever had a severe reaction to a medicine, vaccine or food to carry an adrenaline autoinjector (EpiPen or Jext) | YES | NO |
| Are you pregnant or planning to get pregnant in the next 3 months? | YES | NO |
| Are you breastfeeding? | YES | NO |
| Have you had confirmed a Covid-19 infection in the last 4 weeks? | YES | NO |
| Have you had the flu vaccine in the last 7 days? | YES | NO |
| Have you had a dose of Covid-19 vaccine in the last 21 days? | YES | NO |
| If this is your second does, did you have an adverse reaction to your first? | YES | NO |
| Are you taking part in any clinical trials involving medicines or vaccines? | YES | NO |
| Are you raking any meds that affect blood clotting or for blood thinning? Examples aspirin clopidogrel apixiban rivaroxaban | YES | NO |
| If you take warfarin, are you awaiting an INR result or was your latest INR result higher than your target range? | YES | NO |
| Do you have bleeding problems or a bleeding disorder? | YES | NO |

**For completion by vaccinator only …**

|  |  |  |
| --- | --- | --- |
| HAS THE VACCINE RECIPIENT READ THE WRITTEN INFORMATION PROVIDED? | YES | NO |
| IS THE PERSON BEING ASSESSED HAPPY TO RECEIVE THE COVID-19 VACCINE FOLLING AND ASSESSMENT BY A VACCINATOR | YES | NO |
| IS IT NECESSARY TO MONITOR FOR 15 MINUTES – DOES THE PATIENT AGREE | YES | NO |