

NHS staff COVID-19 vaccination form

Your information: Your personal information and any immunisation you have will be recorded and shared within the NHS for the purpose of record-keeping and vaccine-monitoring. If you wish to find out how the NHS uses your information, please visit:

www.nhsdirect.wales.nhs.uk/lifestylewellbeing/yourinfoyourrights.

*see paper consent form reference list

PLEASE USE BLOCK CAPITALS

Patient details

Date of appointment/attendance:		Time of appointment/attendance:	
Full name (First name and surname):		Date of birth: (DD/MM/YYYY)	
Sex (not mandatory):	Male	Female	Ethnic group*:
Home address:		Eligibility group*:	
Postcode:			
Telephone number:		Mobile number:	
Email address:		Preferred contact language: (please circle)	English Welsh
Name and address of GP:		Preferred contact method (please circle):	
		Letter	Telephone Text

Employment details

(* please use reference list overleaf)

Patient facing (circle one)	Yes No	Sector*	
Employing/ contracting organisation*		Main location of work (local authority)	
Job role*		Employee number (optional)	

To make sure the vaccine is suitable for you, please circle responses to all the questions below.

Please provide any additional details to responses in the free text box below.

Are you unwell today in any way?	Yes	No
Have you had new symptoms of COVID-19 infection or tested positive for COVID-19 in the last 28 days?	Yes	No
Are you being investigated or do you have a serious disability or have you had a deterioration following prolonged COVID-19 symptoms?	Yes	No
Do you have any allergies? Are you allergic to polyethylene glycol (PEG)?	Yes	No
Have you ever had an anaphylactic reaction?	Yes	No
Have you received any vaccine in the last 7 days?	Yes	No
Do you have a condition or receive treatment that severely affects your immune system?	Yes	No
Are you pregnant? Could you be pregnant? Are you planning a pregnancy in the next 3 months? Are you breastfeeding?	Yes	No
Do you have a bleeding disorder or are you taking any blood thinners?	Yes	No
FOR THE IMMUNISER/ASSESSOR: Is there any contraindication to or reason to postpone vaccination today?	Yes	No

Consent for immunisation

(3 options available: 1. written consent by individual 2. verbal consent 3. Implied consent)

I give consent to receive a COVID-19 vaccination	Signature:		Date:
Signature of person taking verbal or implied consent (also PRINT name if not the immuniser)	Verbal:	Implied:	Date:

Free text box (eligibility notes or relevant details)

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Vaccination record						
(for completion by the immuniser)						
Date and time	1.Vaccine and product name 2.Diluent manufacturer*	Batch number 1.Vaccine 2.Diluent*	Expiry date	Site of injection	Route of administration	Dose (please tick)
						1st

*Only necessary for Pfizer COVID-19 vaccine

Immuniser and site details	
Name of immuniser (please PRINT)	Signature of immuniser
Immunisation session location name	Immunisation session location address
	Postcode:

Adverse reaction record					
Adverse reaction (please circle)	Yes	No	Type of adverse reaction (please tick)	Local reaction only	
				Syncope (faint)	
				Allergic reaction	
				Anaphylactoid reaction	
				Full anaphylaxis	
Adverse reaction notes:					