

COVID-19 Vaccination Program Individual Personal Record

Section 1: Personal Details *(to be completed by vaccinee)*

First name

Surname

Date of birth

— —

Age

Gender

Male

Female

Prefer not to say

Home address

Postcode

NHS number

— —

GP name

GP practice

GP address

LHCH Trust employee

NHS other Trust employee

Social care employee

Care home employee

Local authority employee

LHCH Inpatient

LHCH Outpatient

Primary care patient

Care home patient

Section 2: Consent *(to be completed by vaccinee)*

Please confirm the following statements by placing a tick in the box:

1. I confirm I have received and read the COVID-19 vaccine information leaflet. (tick)
2. I confirm I understand the risks and benefits of the COVID-19 vaccine being offered. (tick)
3. I understand that I must rebook and attend for the second dose of the vaccine as scheduled. (tick)
4. I consent to receiving the 1st and 2nd dose of the COVID-19 vaccine. (tick)

Signature

Date

— —

If you are completing this form on behalf of the individual in their best interest, please state:

Name

Relationship

Date of Birth

— —

Section 3: Pre-screening Assessment *(to be completed by vaccinee)*

Are you feeling unwell today?	No	Yes	exclude: do not give
Do you have any COVID-19 symptoms? <i>(i.e. high temperature, a new continuous cough, a loss or change with your sense of smell or taste)</i>	No	Yes	exclude: advise to self isolate
Do you have a history of allergic reactions to any of the Covid vaccine ingredients or anaphylaxis after 1st dose?	No	Yes	exclude: do not give
Do you have a history of immediate onset anaphylaxis to multiple classes of drugs or unexplained anaphylaxis?	No	Yes	exclude: do not give
Are you or could you be pregnant? If yes, email vaccine@lhch.nhs.uk for further consultation	No	Yes	exclude: do not give
Are you breastfeeding?	No	Yes	read current Gov information
Have you had a previous dose of the COVID-19 vaccine?	No	Yes	
If yes, what was the date? — —			do not give if within 18- days of 1st dose
What was the brand? Pfizer mRNA vaccine BNT162b2	No	Yes	do not give if not Pfizer
If not Pfizer please specify			
Have you participated in a COVID-19 vaccine clinical trial?	No	Yes	confirm not had active drug
Have you had confirmed COVID-19 infection in last 4-weeks?	No	Yes	exclude: do not give
Have you received any other vaccine in the last 7-days?	No	Yes	exclude: do not give
Are you immunosuppressed?	No	Yes	counsel on potential for reduced response
Are you taking anticoagulants?	No	Yes	apply pressure post injection
Do you have a disorder that makes you prone to bleeding?	No	Yes	apply pressure post injection
Are you under 16-years of age?	No	Yes	exclude: do not give
Have you had a previous non-anaphylactic reaction to a COVID-19 vaccine? If yes, email vaccine@lhch.nhs.uk for further consultation	No	Yes	
Do you have a BMI over 40?	No	Yes	use longer needle

If you have answered yes to any of the above please provide further details:

Name:

Date of birth: — —

Section 4: Eligibility and Administration Record *(to be completed by vaccinator if no access to online NIMS database)*

I have confirmed the individual's personal details as per section 1? Yes

Does the individual meet any exclusion criteria? No Yes exclude: do not give

Has the individual had the opportunity to ask any questions? No Yes

Has the individual provided signed consent in section 2? No Yes

Are any additional precautions or advice required? (e.g. bleeding risk)? No Yes

If yes please provide details:

Vaccination site: Right deltoid Left deltoid Other (note this is off-label)

If other, state site and rationale:

Is this the 1st / 2nd dose?: 1st dose 2nd dose

Batch number:

Time of administration: —

Size of needle used?: Standard (23G x 25mm) Longer (23G x 38mm)

Please provide details of any advice given on discharge about adverse effects:

Advised on 15-min post vaccine wait time? Yes

Vaccinator first name:

Vaccinator surname:

Profession: Doctor Nurse / Midwife Nursing Associate Pharmacist

Operating department practitioner Physiotherapist Paramedic

Other, please state:

Section 5: Adverse Drug Reaction *(to be completed by vaccinator)*

Did a reaction occur? No Yes

If yes, please give details:

If yes, please complete yellow card report via MHRA (<http://coronavirus-yellowcard.mhra.gov.uk>)