Registered practice:_____
Vaccination date:_____

** The information provided on this form is confidential between patient and clinician **

First Name		**Date of birth**	
Surname			
Home address			
		Postcode	
Phone/Mobile		**Email address**	

Please read and answer the following questions carefully. Information provided will be used to assess your suitability to receive the Covid-19 vaccine. If you answer yes to any questions, you may be asked for further information to assess your suitability to receive the Covid-19 vaccine.

Are you under 16 years of age?	No ☐	Yes☐
Do you currently have a severe illness with a high temperature?	No ☐	Yes☐
Have you ever had a severe reaction to a medicine, vaccine or to food or carry an adrenaline autoinjector (such as EpiPen® or Jext®)?	No☐	Yes☐
Are you pregnant, think you might be pregnant or planning to get pregnant in the next three months? Refer to 'COVID-19 vaccination: a guide for women of childbearing age, pregnant, planning a pregnancy or breastfeeding' for information.	No☐	Yes☐
Are you breastfeeding?	No☐	Yes☐
Have you had confirmed Covid-19 infection in the last 4 weeks?	No☐	Yes☐
Have you had the flu vaccine in the last 7 days?	No☐	Yes☐
Have you had a dose of the Covid-19 vaccine in the last 21 days?	No☐	Yes☐
If this is your second dose of the Covid-19 vaccine, did you have an adverse reaction to the first dose?	No☐	Yes☐
Are you taking part in any clinical trials involving medicines or vaccines?	No☐	Yes☐

Are you taking any medicines that affect blood clotting or for blood thinning? Examples of these medicines include [redacted] apixaban, rivaroxaban, dabigatran or edoxaban.	No☐	Yes☐
If you take warfarin, are you awaiting an INR result or was your latest INR result higher than your target range?	No☐	Yes☐
Do you have bleeding problems or a bleeding disorder?	No ☐	Yes☐

FOR COMPLETION BY VACCINATOR ONLY - Consent to vaccination

Has the vaccine recipient read the written information provided?	Yes☐	No☐
Is the person being assessed happy to receive the Covid-19 vaccine following assessment by a vaccinator?	Yes☐	No☐
Does the vaccine recipient agree to be monitored for at least 15 minutes following vaccination as there is a small risk of significant adverse reactions to the vaccine?	Yes☐	No☐

Patients ethnicity _____

Vaccination site (circle)	Left arm	Right Arm
Time of vaccination		
Vaccinating clinician	Name (Print):	Signature: