SECOND DOSE VACCINATIONS

Registered Practice:	Vaccination date:

ARE YOU A CARER?	Adult unpaid carer for friend or relative	YES	NO
	In an elderly care home – if YES please state where below:	YES	NO

Full name:	
Date of birth:	
Home address:	Telephone number:
Patients ethnicity:	

Are you under 16?	YES	NO
Do you currently have a severe illness with high temperature?	YES	NO
Since your last COVID-19 vaccination have you had COVID-19 symptoms or had a positive COVID-19 test?	YES	NO
Did you experience a severe allergic reaction to your first dose of COVID-19 vaccination?	YES	NO
IF you are on warfarin treatment – was your last INR blood test in range?	YES	NO
Are you taking any medicines that effect blood clotting or blood thinning? Ex. Apixaban, Rivaroxaban, Dabigatran or Edoxaban	YES	NO
Are you pregnant, think you might be pregnant or are you planning to get pregnant within the next three months?	YES	NO
Are you breastfeeding?	YES	NO
Have you had any other vaccine injected in the last 7 days? If so what?	YES	NO
Are you taking part in any clinical trials involving medicines or vaccines?	YES	NO

To be completed by clinician-

Does the patient consent to vaccination?	YES	NO
Does the patient agree to be monitored for 15 minutes following vaccination if there is a small risk of significant adverse reactions to the vaccine?	YES	NO

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