



COVID-19 Vaccination Service – Record form

Autumn/Winter 2025/26 Vaccine

This form should be used if you are unable to access the platform.

Please complete the form in **BLOCK capitals**

Pre-screening Clinician	
First name	
Surname	
Professional body registration no.	
Signature	
Consultation	
Booking reference	
Vaccination date	
Patient's Details	
Patient name	
Date of birth	
Gender	
Postcode	
Address	
NHS No.	
Telephone number	
GP Practice	
Emergency Contact (optional)	
Name	
Telephone number	
Relationship	
Vaccination Setting	
Setting	<input type="checkbox"/> Vaccination site <input type="checkbox"/> Care home or other residential setting <input type="checkbox"/> Home of housebound patient <input type="checkbox"/> Outreach event
For Care Home use only	
CQC Number	
Care Home Name	

Care Home Postcode	
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For Residential Facility use only		
Residential Facility Name		
Residential Facility Address		
Residential Facility Postcode		
Eligibility		
Eligibility	<input type="checkbox"/> Individual lives in a care home <input type="checkbox"/> Individual is eligible due to their age <input type="checkbox"/> Individual is immunosuppressed	
Clinical Screening (tick as appropriate)		
	Yes	No
Is the individual severely immunosuppressed?		
Has the individual indicated they are, or could be pregnant? (12 years and over)		
Does the individual have a history of anaphylaxis or significant allergic reactions to any vaccine or its ingredients?		
Has the individual experienced any serious adverse reaction after previous COVID-19 vaccine doses?		
Clinically Suitable		
	Yes	No
Has the clinician confirmed that the individual is suitable to proceed to vaccination following consideration of the vaccine specific screening questions?		
Consent		
	Yes	No
Consent given to receive the vaccine.		
Consent given by	<input type="checkbox"/> Patient <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Healthcare Lasting Power of Attorney <input type="checkbox"/> Court Appointed Deputy <input type="checkbox"/> Independent Mental Capacity Advocate (IMCA) <input type="checkbox"/> Clinician using Best Interests process of Mental Capacity Act	
If consent was not given by the Patient themselves, then please complete the below fields:		
Individual Consulted		
Authorising Clinician		
Registration Number		
Notes (e.g. relationship to patient)		
Outcome		
Outcome	<input type="checkbox"/> Continue with vaccine administration <input type="checkbox"/> Vaccination not given (see 'Vaccine not given' section below)	
Vaccination Details		
Date of vaccination		
Time of vaccination		
Dose sequence	<input type="checkbox"/> First Administration <input type="checkbox"/> Second Administration <input type="checkbox"/> Booster vaccination	
Drawn up by		

Vaccinator	
Vaccine type	<input type="checkbox"/> Comirnaty KP.2 adults and adolescents from 12 years COVID-19 mRNA Vaccine 30micrograms/0.3ml dose dispersion for injection multidose vials (Pfizer Ltd) <input type="checkbox"/> Comirnaty LP.8.1 Children 5-11 years COVID-19 mRNA Vaccine 10micrograms/0.3ml dose dispersion for injection single dose vials (Pfizer Ltd) <input type="checkbox"/> Comirnaty JP.8.1 Children 6 months - 4 years COVID-19 mRNA Vaccine 3micrograms/0.3ml dose concentrate for dispersion for injection multidose vials (Pfizer Ltd)

Batch number	
Manufacturer's expiry date	
Use by date	
Administration site	<input type="checkbox"/> Left deltoid <input type="checkbox"/> Right deltoid <input type="checkbox"/> Left thigh <input type="checkbox"/> Right thigh
Route of administration	<input type="checkbox"/> Intramuscular
Advice provided and vaccination completed	<input type="checkbox"/> When to seek advice <input type="checkbox"/> When next dose is due, if applicable <input type="checkbox"/> For Comirnaty (Pfizer) observe for 15 minutes if previous history of a reaction <input type="checkbox"/> Do not drive for 15 minutes
Vaccination delivered under	<input type="checkbox"/> National Protocol <input type="checkbox"/> Patient Group Direction <input type="checkbox"/> Patient Specific Direction
If additional practitioners have been involved under the National Protocol enter their names/roles here:	

Reaction

Patient suffered adverse reaction	<input type="checkbox"/> Yes <input type="checkbox"/> No
Manifestation of reaction	
Reaction severity	<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Description of reaction	

Non-Vaccination

Vaccination dose not given	<input type="checkbox"/> First Administration <input type="checkbox"/> Second Administration <input type="checkbox"/> Booster vaccination
Reason for not vaccinating	<input type="checkbox"/> Symptomatic or generally unwell <input type="checkbox"/> Immunisation is contraindicated <input type="checkbox"/> Immunisation consent was not given

Clinical Notes

Clinical notes and advice	
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