

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	 □ Vaccination site □ Care home or other residential setting □ Home of housebound patient □ Outreach event 			
For Care Home use only				
CQC Number				
Care Home Name				

	For Residential Facility use only					
Residential Facility Name						
Residential Facility Address						
Residential Facility Postcode						
	 Eligibility					
Eligibility	 □ Individual lives in a care home □ Individual is eligible due to their age □ Individual is immunosuppressed 					
Clinical Screening (tick as appropriate)						
		Yes	No			
Is the individual severely immunosu	ppressed?					
Has the individual indicated they are	e, 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					
	Consent					
	Ochson	Yes	No			
Consent given to receive the vaccin		Yes	No			
Consent given to receive the vaccin Consent given by	e. Patient Parent/Guardian Healthcare Lasting Power of Attorney Court Appointed Deputy Independent Mental Capacity Advocate (IMCA)	Yes	No			
Consent given by	e. Patient Parent/Guardian Healthcare Lasting Power of Attorney Court Appointed Deputy Independent Mental Capacity Advocate (IMCA)	Yes	No			
Consent given by	e. Patient Parent/Guardian Healthcare Lasting Power of Attorney Court Appointed Deputy Independent Mental Capacity Advocate (IMCA) Clinician using Best Interests process of Mental Capacity Act	Yes	No			
Consent given by If consent was not given by the Pati	e. Patient Parent/Guardian Healthcare Lasting Power of Attorney Court Appointed Deputy Independent Mental Capacity Advocate (IMCA) Clinician using Best Interests process of Mental Capacity Act	Yes	No			
Consent given by If consent was not given by the Pati Individual Consulted	e. Patient Parent/Guardian Healthcare Lasting Power of Attorney Court Appointed Deputy Independent Mental Capacity Advocate (IMCA) Clinician using Best Interests process of Mental Capacity Act	Yes	No			
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Consent given by If consent was not given by the Pati Individual Consulted Authorising Clinician Registration Number Notes (e.g. relationship to patient)	e. Patient Parent/Guardian Healthcare Lasting Power of Attorney Court Appointed Deputy Independent Mental Capacity Advocate (IMCA) Clinician using Best Interests process of Mental Capacity Act ent themselves, then please complete the below fields: Outcome Continue with vaccine administration	Yes	No			
Consent given by If consent was not given by the Pati Individual Consulted Authorising Clinician Registration Number Notes (e.g. relationship to patient)	e. Patient Parent/Guardian Healthcare Lasting Power of Attorney Court Appointed Deputy Independent Mental Capacity Advocate (IMCA) Clinician using Best Interests process of Mental Capacity Act ent themselves, then please complete the below fields: Outcome Continue with vaccine administration Vaccination not given (see 'Vaccine not given' section below)	Yes	No			
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Care Home Postcode

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If additional practitioners have been involved under the National Protocol enter their names/roles here: Reaction			•
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Moderate Severe	Reaction severity		Mild
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