WaltonPharmacy
Putting your Health First

Id Checked by: **AZ/OXFORD VACCINE** **Appointment Time:**

SECTION A: PATIENT DETAILS	
First Name	
Surname	
Gender *(Tick box)*	Male ☐ Female ☐
Address	
Post Code	
Telephone	
Emergency contact number	
Date of Birth	
NHS number	

SECTION B: HEALTH QUESTIONS – Answer all the questions and tick the relevant boxes				
Have you had the first dose of COVID vaccine?	No		Yes	
If yes, any allergies including anaphylaxis to COVID vaccine?	No		Yes	
If yes, have you experienced major venous and/or arterial thrombosis occurring with thrombocytopenia following vaccination with any COVID-19 vaccine?	No		Yes	
Have you had any serious allergies resulting in **anaphylaxis** or hospital admission to allergic reaction to any other vaccines or injections or medications?	No		Yes	
Do you have a history of cerebral venous sinus thrombosis, or antiphospholipid syndrome?	No		Yes	
Do you have a history of heparin-induced thrombocytopenia and thrombosis (HITT or HIT type 2)?	No		Yes	
Are you pregnant or planning to be pregnant in the next 2 months? Or are you breastfeeding?	No		Yes	
Have you had any other vaccinations in the past 7 days?	No		Yes	
Have you had the COVID infection within the last month?	No		Yes	
Will you be **driving** after the vaccination? *(If YES: you are advised not to drive for 15 minutes after the vaccination)*	No		Yes	
Are you on any anti-coagulants e.g Warfarin or do you have a bleeding disorder?	No		Yes	
Have you taken part in the Covid-19 vaccine trial?	No		Yes	

CONSENT FOR IMMUNISATION

I have answered all the questions in Section B and consent to receive the COVID vaccination. I am aware that the information that I have had the COVID-19 vaccination will be shared with NHS England as data controller on vaccination uptake for the trust to data monitoring purposes.

Signature of patient: _____

Consent given by: Patient ☐ Representative ☐

If Representative, nature of relationship to patient?

_____

Date: _____ /_____ /2021
(DD/MM/YYYY)

NHS
COVID-19
Vaccination Centre