WaltonPharmacy
Putting your Health First

Id Checked by: **Appointment Time:**

PFIZER VACCINE BOOSTER

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

SECTION B: HEALTH QUESTIONS – Answer all the questions and tick the relevant boxes				
Have you experienced myocarditis or pericarditis determined as likely to be related to previous COVID-19 vaccination?	No		Yes	
Have you experienced major venous and/or arterial thrombosis occurring with thrombocytopenia following vaccination with any COVID-19 vaccine?	No		Yes	
Are you currently unwell with fever or any COVID-19 symptoms?	No		Yes	
Have you ever had any serious allergic reaction to any ingredients of the Covid-19 vaccines, drug or other vaccine?	No		Yes	
Have you ever had an unexplained anaphylaxis reaction?	No		Yes	
Does the individual have a history of heparin-induced thrombocytopenia and thrombosis (HITT or HIT type 2)?	No		Yes	
Does the individual have a history of capillary leak syndrome?	No		Yes	
Have you had any vaccination in the last 7 days?	No		Yes	
Are you or could you be pregnant?	No		Yes	
Are you taking anticoagulant medication, or do you have a bleeding disorder?	No		Yes	
Have you had COVID-19 in the last 28 days?	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. I am aware that I am REQUIRED TO WAIT 15 MINUTES INSIDE THE PHARMACY AFTER YOUR VACCINATION

Signature of patient:
_____

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

Consent given by: Patient ☐
Representative ☐
If Representative, nature of relationship to patient?
_____

NHS
COVID-19
Vaccination Centre

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