Pfizer BioNTech/ COMINARTY 16/17 year (White)	BOOKED		Walsall Healthcare NHS Trust	Saddlers Mass Vaccination	ARRIVAL TIME:	ZONE NO:	BOOTH NO:
	WALK IN						

COVID-19 Vaccination Recipient Eligibility, Consent Form & Pre – Screening Record (BLOCK CAPITALS PLEASE)

SURNAME		**FORENAME**	
DATE OF BIRTH		**NHS NUMBER**	
1st LINE OF ADDRESS		**POSTCODE**	
GP Name	**GP Address**	**Telephone No**	

ETHNICITY (Please tick one)	White		Asian/Asian British		Arab		Black/African/Caribbean/Black British	
	Mixed		Mixed/multiple ethnic groups		Other ethnic group		Prefer not to say	

Email Address	*(personal)*	**Mobile Telephone No**	
Employee Number		**Job Role**	**Patient Carer Care Worker Other**
Organisation	**School or College or university If other, please state……**		

Please indicate if this is: **(Please circle one)** (17 years and 9 months require 2 doses)	Is this your FIRST Covid-19 vaccination: Yes No Are you 18 years in the next 3 months Yes No	**Known Allergies (please list or write 'none'):** **Have you had your vaccine abroad?** **If so where?** **Which vaccine did you have?**

Pre-vaccination Screening		**Circle**	
1.	Are you currently unwell with a fever?	**Y**	**N**
2.	**Have you had a previous systemic allergic reactions (including immediate onset anaphylaxis) to a previous dose of COVID-19 mRNA Vaccine BNT162b2 or COVID-19 Vaccine AstraZeneca, (ChAdOx1-S [recombinant]) or to any component of the vaccine or residues from the manufacturing process?** **Have you experienced an urticarial (itchy) skin reaction following COVID 19 vaccine?**	**Y** **Y**	**N** **N**
3.	**Have you ever had a history of immediate-onset anaphylaxis to multiple classes of drugs or unexplained anaphylaxis?**	**Y**	**N**
4.	Do you have a history of heparin-induced thrombocytopenia and thrombosis (HITT or HIT type 2)?	**Y**	**N**
5.	Have you experienced major venous and/or arterial thrombosis occurring with thrombocytopenia following vaccination with any COVID-19 vaccine?	**Y**	**N**
6.	Do you have a history of capillary leak syndrome?	**Y**	**N**
7.	Are you or could you be pregnant?	**Y**	**N**
8.	Are you participating in a clinical trial of potential COVID-19 vaccines?	**Y**	**N**
9.	Are you taking any anticoagulant medication or blood thinning medication e.g. warfarin? If yes, is you INR above the upper threshold for your condition? Do you know your warfarin range? What is it: ……	**Y**	**N**
10.	Do you have a bleeding disorder e.g. haemophilia?	**Y**	**N**
11.	Do you currently have any symptoms of COVID-19 infection? Have you tested positive for COVID-19 within the past 28 days?	**Y**	**N**
12.	**Do you consent to the vaccination?**	**Y**	**N**
	If You or the person presenting for vaccination are uncertain as to the response to any questions please seek advice from the Nurse/Pharmacist or lead Clinician as required for further advice E.g. Safeguarding , Consent , Mental Capacity etc.		

Please tick all relevant boxes and sign and date below:

- ☐ **BOX A:** I have read the information sheet and consent to receiving the COVID 19 vaccination. I am aware that the National Immunisation Vaccination (NIV) service / PharmOutcomes system and other Healthcare providers will be informed I have been vaccinated.
- ☐ **BOX B:** I have had the pre-screening and following the pre-vaccination screening I am NOT eligible for vaccination.
- ☐ **BOX D:** I have received the what to Expect after Covid 19 Vaccination CYP leaflet
- ☐ **BOX C:** I have received information on Pregnancy

Patients Signature		Date:
Clinical Assessor	Name: Signature	PIN/REG

Vaccination details – administered via National protocol or PGD for:
COVID-19 mRNA vaccine BNT162b2 (Pfizer/BioNTech/COMINARTY) CURRENT VERSION

Please attach vaccine label – to include vaccine name, amount in mls to be given, batch number and expiry date:

VACCINE ADMINISTERED: YES

Sticker: Pfizer – BioNTech COVID19 Vaccine Dose 0.3ml for INTRAMUSCULAR USE ONLY - Store in Fridge – Protect from light **Batch no:** **Expiry time:** **Recons by:** **Checked by:** **Drawn by:** **Given By:**			**Vaccination Date:**
			Vaccinator Profession:
			Vaccinator ID:
			Vaccinator Name / Stamp: *PLEASE ENTER NAME IN CAPITALS*
			Vaccination Site: Left upper arm ☐ / Right upper arm ☐
			Which Dose: First dose of vaccine ☐ / Second dose of vaccine ☐
			Vaccinator Signature:
Do they consent to the vaccine? **Advice Given re: safety netting**	Yes	No	**Date:** **Time (24 hour):**

Advice re further Appointment if required yes / no	***SIMPLY BOOK ONLY***	**Date and Time of Appointment:**

VACCINE ADMINISTERED: NO

Not vaccinated reason	Immunisation course contraindicated	☐	**Narrative for non-vaccination reason** (i.e. anaphylaxis multiple drugs)
	Immunisation course declined	☐	
	Immunisation course not done	☐	
	Immunisation course not indicated	☐	
	Vaccination dose declined	☐	Action Taken: Have you referred back to GP Yes or No if not why?
	Vaccination dose not given	☐	
	Referred to GP	☐	

ADVERSE REACTIONS *(Please circle)*

Reaction Type	Allergy		Intolerance
Reaction *(Please refer to sheet at data entry desk)*			
Criticality/Severity	High	Low	Unable to assess
Date First Experienced			
Verification Status	Confirmed		Suspected

OBSERVATIONS

Recorded observations for any assistance required for the patient and actions taken

Date:		**PIN Number:**	
Time:		**Staff Name:** **Staff Signature:**	

Comments: