

Staff		Resident		Housebound		Other	
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Lichfield PCN Covid 19 Vaccination Site: Greenhill Health Centre

Practice Name:
THE WESTGATE PRACTICE

Name		Surname	
Date of Birth		NHS Number	(if known)
Home Address Including Postcode			

The person presenting for vaccination must answer all the questions below (especially in relation to allergies) and confirm that they have received appropriate counselling as to the purpose of the vaccine, side effects and that they wish to proceed to vaccination.

Pre-vaccination screening		Please circle	Helpful notes
1.	Do you have a history of anaphylaxis or significant allergic reactions to any vaccines or its ingredients?	Y / N	
2.	Have you experienced any serious adverse reaction after previous COVID-19 vaccine doses?	Y / N	

To be completed by Clinician/Administrator

Batch No	Expiry date	Use by date	Vaccine administered by	Vaccine constituter	Date and time	Site of injection