Kingsbridge Medical Practice 0300 123 1892

PLEASE BRING THIS FORM WITH YOU TO THE VACCINATION CLINIC

Name		**Surname**	
Date of Birth		**NHS number:**	
Please indicate if this is	Your FIRST Covid-19 vaccination dose: Yes Your SECOND Covid-19 vaccination dose: Yes If this is your second vaccination, what was the date of your first vaccination? DATE:		

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

	Pre-vaccination screening	Please circle	
1	Are you pregnant or planning to be pregnant within the next 2 months?	Y / N	**If you answer YES to any questions:** **CONTACT KINGSBRIDGE MEDICAL PRACTICE TO SEEK FURTHER ADVICE ON TELEPHONE NUMBER:** **0300 123 1892**
2	Do you have antiphospholipid syndrome or have you had any blood clots which were associated with a low platelet count.	Y / N	
3	Do you have a significant allergic / hypersensitivity reaction to **any vaccine, vaccine component, medicine or food** (such as allergies resulting in anaphylaxis, hospital admission, severe skin reactions, bronchospasm / respiratory effects)?	Y / N	
4	Have you been advised for any reason to carry an adrenaline auto-injector (e.g. EpiPen®)	Y / N	
5	Have you had any other vaccinations in the last 7 days particularly the influenza (flu) vaccination?	Y / N	
6	Have you participated in a national COVID 19 vaccine clinical trial? If the answer is YES then clarification is required whether active or placebo given in trial	Y / N	
7	Have you had a Covid positive test within the past 28 days?	Y / N	
8	Do you have a bleeding disorder e.g. haemophilia?	Y / N	
9	Are you taking Warfarin or any other blood thinning medication) **– go to Q.10**	Y / N	If yes, vaccination still likely to be possible depending on answer to **Q.10**
10	If you are on warfarin, do you have an INR blood test of less than 3.5?	Y / N / NA	If YES proceed with vaccination; recipient to ask GP for further advice if NO

Please tick box A or B and sign and date below.

☐ **BOX A:** I have read the information sheet and consent to receiving the Covid 19 vaccination

☐ **BOX B:** I have read the information sheet and following the pre-vaccination screening I am **NOT** eligible for vaccination.

Signature:		**Date:**