

NHS Flu Vaccination Service - Record Form

* indicates sections that must be completed

Patient's details																			
First name*																			
Surname*																			
Address*																			
Postcode																			
Telephone																			
Date of birth*																			
GP practice*																			
Patient's emergency contact																			
Name																			
Telephone																			
Relationship to patient																			
Any allergies																			
Eligible patient group*	<input type="checkbox"/> 50-64 years (not in a clinical at-risk group)										<input type="checkbox"/> Chronic respiratory disease								
	<input type="checkbox"/> 65 years or over										<input type="checkbox"/> Chronic kidney disease								
	<input type="checkbox"/> Chronic heart disease										<input type="checkbox"/> Chronic neurological disease								
	<input type="checkbox"/> Chronic liver disease										<input type="checkbox"/> Immunosuppression								
	<input type="checkbox"/> Diabetes										<input type="checkbox"/> Pregnant woman								
	<input type="checkbox"/> Asplenia / splenic dysfunction										<input type="checkbox"/> Carer								
	<input type="checkbox"/> Person in long-stay residential care home or care facility										<input type="checkbox"/> Morbid obesity (BMI ≥ 40)								
	<input type="checkbox"/> Household contact of immunocompromised individual										<input type="checkbox"/> Learning disability								
	<input type="checkbox"/> Employed through Direct Payment of Personal Health Budget										<input type="checkbox"/> Hospice worker								
	<input type="checkbox"/> Frontline Health & Social care worker																		

Vaccination details

Name of vaccine/ manufacturer*	Apply vaccine sticker if available	Date of vaccination*				Pharmacy stamp					
Batch Number*		Injection site*	<input type="checkbox"/> Left upper arm <input type="checkbox"/> Right upper arm								
Expiry Date*		Route of administration*	<input type="checkbox"/> Intramuscular <input type="checkbox"/> Subcutaneous								
Location (if not in the pharmacy)*	<input type="checkbox"/> Patient's home <input type="checkbox"/> Long-stay care home or long-stay residential facility <input type="checkbox"/> Other location (please state):										
Any adverse effects*											
Advice given and any other notes											
Administered by*		Signature*		Registration number*							