COVID-19 VACCINE RECORD

UNDER PATIENT GROUP DIRECTION

NHS
South Tees Hospitals
NHS Foundation Trust

Complete all boxes - Client to complete self assessment and vaccine consent details

COVID VACCINE PROGRAMME - version 12 - Issued 03/10/2024

FIRST NAME:		**SURNAME:**		**DATE OF BIRTH**
ADDRESS				**POSTCODE**
NHS NUMBER		**TEL NO**		**PAYROLL NO**
CIRCLE ONE OF:	SOUTH TEES NHS	SOUTH TEES OTHER	NHS OTHER	OTHER: (please state)
GP	Name, Address, Postcode			
GENDER	Male, Female, Prefer not to say		**ETHNICITY**	
JOB ROLE			**WORK ADDRESS**	

PRE VACCINATION SELF-ASSESSMENT - PLEASE COMPLETE CIRCLING YES OR NO

Do you have a history of anaphylaxis or significant allergic reaction to COVID-19 mRNA vaccines or any ingredient in COVID-19 mRNA vaccines?			YES / NO
Have you experienced myocarditis or pericarditis determined as likely to be related to previous COVID-19 vaccination?			YES / NO
Are you currently unwell with fever?			YES / NO
Have you had a COVID vaccine within the past 3 months?			YES / NO
Do you have a bleeding disorder or do you take any anticoagulant medication?			YES / NO
Do you take immunosuppressive medication or have a condition which may affect your immune system?			YES / NO
Do you consent to vaccination?	YES / NO	Client signature:	Date

VACCINATOR TO COMPLETE THIS SECTION

COVID-19 VACCINE	**Spikevax® JN.1 (0.1mg/mL) dispersion for injection** 0.5mL via intramuscular injection		CONSENTED:	YES / NO
BATCH NUMBER	BATCH EXPIRY	DEFROST EXPIRY	VACCINATION SITE:	LEFT RIGHT
PRINT VACCINATOR NAME		SIGNATURE	REG NO	DATE
DETAIL ANY ADVICE GIVEN OR ANY ADVERSE DRUG REACTION AND ACTIONS TAKEN. Adverse reactions should be recorded via Yellow Card Scheme.				