Community Pharmacy Influenza Vaccination Consent Form

To be completed before administering influenza vaccination and retain for 2 years.

Your vaccination appointment details are below.

A flu vaccination has been reserved for you.

Please do not book another appointment with another provider. If you cannot attend for your appointment, please let the pharmacy know immediately and reschedule your appointment. Failure to attend for your flu vaccination costs the NHS, please help us to make the best use of all NHS resources during this challenging time. Thank you.

Location	
Date & Time	

All Vaccinations – please complete this section before your appointment	
Patient Name	
Patient Address	
Postcode	
Date of Birth	
Emergency Contact Name & Tel.	
GP Surgery	

NHS Vaccinations Only – please complete this section before your appointment		
Risk Group for NHS Vaccine (Please tick)	Aged 65 years or over	
	Asthma	
	Diabetes	
	Heart Disease	
	Kidney Disease	
	Liver Disease	
	Neurological Disease	
	Immunosupression	
	Pregnant	
	Living in long stay Care Home	
	Carer (unpaid)	

All Vaccinations - please complete this section on the day of your appointment				
Have you had a flu vaccination this year?	Yes	☐	No	☐
Are you unwell today? e.g. temperature or infection?	Yes	☐	No	☐
Have you had a serious reaction to the flu vaccine in the past?	Yes	☐	No	☐
Are you allergic to eggs or egg products?	Yes	☐	No	☐
Do you take any blood thinning medication like warfarin?	Yes	☐	No	☐

Patient Declaration:

I have provided the pharmacist with information that is correct to the best of my knowledge. I have been fully informed on the importance of influenza vaccination and the potential side effects of this vaccine.

My signature below acknowledges my consent for the administration of the vaccine and for the details to be passed to my GP and anonymously shared with the Local Health Board.

All Vaccinations - please complete this section on the day of your appointment	
Patient Signature	
Print Name	
Date	

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To be completed by the pharmacist on the day of appointment

Pharmacist Declaration:

The action specified was based on the information given to me by the patient, which to the best of my knowledge is correct.

Is the patient eligible for a vaccination?	Yes	☐	No	☐
Does the patient wish to receive the vaccination?	Yes	☐	No	☐

Pharmacist Name & GPhC Registration		Pharmacist Signature	
Vaccine Name	Batch / LOT Number	Expiry Date	Site of Injection L R Deltoid