

Forest Hill Pharmacy Influenza Vaccination Record & Consent Form

* indicates sections that must be completed

Patient's details			
First name*			
Surname*			
Address			
Postcode			
Telephone			
Date of birth*		NHS Number	
GP practice*			
Patient's emergency contact			
Name			
Telephone			
Relationship to patient			
Patient consent			
<p>1. I agree to be given a flu vaccination by a trained pharmacist.</p> <p>2. I confirm I have not already received a flu vaccination for this flu season.</p> <p>3. I declare that the information I have given on this form is correct and complete.</p> <p>4. I consent to the disclosure of relevant information, where appropriate, from this form to:</p> <ul style="list-style-type: none"> ▪ my GP practice to help them provide care to me; and ▪ NHS England (the national NHS body that manages pharmacy and other health services) for the purposes of checking payments to the pharmacy and to allow them to make sure the service is being provided properly. 			
Signature			Date

To be completed by pharmacy staff

Any allergies					
Eligible patient group*	<input type="checkbox"/> Aged over 65	<input type="checkbox"/> Chronic respiratory disease			
	<input type="checkbox"/> Chronic heart disease	<input type="checkbox"/> Chronic kidney disease			
	<input type="checkbox"/> Chronic liver disease	<input type="checkbox"/> Chronic neurological disease			
	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Immunosuppression			
	<input type="checkbox"/> Splenic dysfunction	<input type="checkbox"/> Pregnant woman			
	<input type="checkbox"/> Person in long-stay residential or home	<input type="checkbox"/> Carer			
	<input type="checkbox"/> Household contact of immunocompromised individual				

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			

Any adverse effects*						
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Advice given and any other notes						
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Administered by* <small>(pharmacist name)</small>		Signature*		GPhC number*							
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