Vaccine Record Form

Vaccine not given (reason)

Name	Cydney Morgan		
DOB	29-Feb-2020 (Under 18 - Check Vaccine Suitability)		
NHS No.	889811349		
Address	123 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice

Screening Questi	Screening Questions (FOR COMPLETION BY PATIENT)				No
	If you answer YES to any of these questions, or are unsure, please discuss with your vaccinator				
1. Are you feeling unwell today, for example, a high temperature or are antibiotics?					
2. Do you suffer from severe allergies, or have have ever had a severe allergic reaction?					
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?					
Consent FOR COMPLETION	ON IN THE EVENT OF A	N IT OUTAGE			
Consent given?	Yes No				
Consent Provided By:	Patient LPA for Healt	h Court Appointed Dep	uty Clinician Best Interests Decisi	on (MCA)	
Vaccination Details FOR (COMPLETION IN THE EV	VENT OF AN IT OUTAGE	=		
Dose Round			First		
Time of Vaccination (24hr) 08:30			Date of Vaccination	20/01/2	021
Vaccine Brand and Batch Number					
Administration Site			Left Right Deltoid Thigh		
Any Adverse Effects (blank	(for none) or other comr	ments			
Vaccinator Name					

1 of 23 13/01/2025, 18:07

Vaccine Record Form

Vaccine not given (reason)

Name	HaHssan Riddle		
DOB	29-Feb-2020 (Under 18 - Check Vaccine Suitability)		
NHS No.	889811349		
Address	123 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice

Screening Questions (FOR COMPLETION BY PATIENT) Yes					No
If you answer YES to any of these questions, or are unsure, please discuss with your vaccinator					
1. Are you feeling unwell today, for example, a high temperature or are antibiotics?					
2. Do you suffer from severe allergies, or have have ever had a severe allergic reaction?					
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?					
Consent FOR COMPLETIC	ON IN THE EVENT OF A	N IT OUTAGE			
Consent given?	Yes No				
Consent Provided By:	Patient LPA for HealtI	h Court Appointed Depu	ıty Clinician Best Interests Decisi	on (MCA)	
Vaccination Details FOR C	COMPLETION IN THE EV	/ENT OF AN IT OUTAGE			
Dose Round			First		
Time of Vaccination (24hr)		08:30	Date of Vaccination 20/01/2021		
Vaccine Brand and Batch Number					
Administration Site			Left Right Deltoid Thigh		
Any Adverse Effects (blank for none) or other comments					
Vaccinator Name					

2 of 23 13/01/2025, 18:07

Vaccine Record Form

Vaccine not given (reason)

Name	Priscilla Gomez		
DOB	3-Aug-2004		
NHS No.	171336314		·· · · _
Address	124 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice

7 (dai 000	12 1 1001 0			0. 1.00000			
Screening	g Questic	ons (FOR COMP	LETION BY F	PATIENT)	,	Yes	No
	If you answer YES to any of these questions, or are unsure, please discuss with your vaccinator						
1. Are you feeling unwell today, for example, a high temperature or are antibiotics?					or are		
2. Do you suffer from severe allergies, or have have ever had a severe allergic reaction?					evere allergic		
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?					d/or Flu		
Consent FOR (COMPLETIC	ON IN THE EVENT OF A	N IT OUTAGE				
Consent given?	?	Yes No					
Consent Provid	led By:	Patient LPA for Healtl	h Court Appointed	d Deputy Clinician E	Best Interests Decision	n (MCA)	
Vaccination De	etails FOR C	COMPLETION IN THE EV	/ENT OF AN IT OU	JTAGE			
Dose Round				First			
Time of Vaccination (24hr) Date of Vaccination			cination	20/01/20	021		
Vaccine Brand and Batch Number							
Administration Site Le			Left Right	Deltoid Thigh			
Any Adverse Ef	ffects (blank	for none) or other comm	nents				
Vaccinator Name							

3 of 23

Vaccine Record Form

Vaccine not given (reason)

Name	Hayden Wilkes		
DOB	14-Jun-1998		
NHS No.	197851747		
Address	125 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice

Screening Questions (FOR COMPLETION BY PATIENT)					No
	If you answer YES to any of these questions, or are unsure, please discuss with your vaccinator				
1. Are you feeling unwell today, for example, a high temperature or are antibiotics?					
2. Do you suffer from severe allergies, or have have ever had a severe allergic reaction?					
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?					
Consent FOR COMPLETIO	ON IN THE EVENT OF AN	N IT OUTAGE			
Consent given?	Yes No				
Consent Provided By:	Patient LPA for Health	h Court Appointed Dep	uty Clinician Best Interests Decisi	on (MCA)	
Vaccination Details FOR C	COMPLETION IN THE EV	/ENT OF AN IT OUTAGE			
Dose Round			First		
Time of Vaccination (24hr)		08:50	Date of Vaccination 20/01/2021		021
Vaccine Brand and Batch Number					
Administration Site			Left Right Deltoid Thigh		
Any Adverse Effects (blank for none) or other comments					
Vaccinator Name					

4 of 23 13/01/2025, 18:07

Vaccine Record Form

Name	Alannah Mullen	回365回 * 6590015	
DOB	21-Jul-2014 (Under 18 - Check Vaccine Suitability)		
NHS No.	251290912		
Address	126 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice

Screening Question	Screening Questions (FOR COMPLETION BY PATIENT)				No
_	If you answer YES to any of these questions, or are unsure, please discuss with your vaccinator				
1. Are you feeling un antibiotics?	1. Are you feeling unwell today, for example, a high temperature or are antibiotics?				
2. Do you suffer from severe allergies, or have have ever had a severe allergic reaction?					
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?					
Consent FOR COMPLETIC	ON IN THE EVENT OF AI	N IT OUTAGE			
Consent given?	Yes No				
Consent Provided By:	Patient LPA for Healt	h Court Appointed Depu	ıty Clinician Best Interests Decisi	on (MCA)	
Vaccination Details FOR C	COMPLETION IN THE EV	VENT OF AN IT OUTAGE			
Dose Round			First		
Time of Vaccination (24hr)		09:00	Date of Vaccination	20/01/2021	
Vaccine Brand and Batch N	lumber				
Administration Site			Left Right Deltoid Thigh		
Any Adverse Effects (blank for none) or other comments					
Vaccinator Name					
Vaccine not given (reason)			Unwell Contraindicated Did n	ot consent	

5 of 23

Vaccine Record Form

Name	Zayan Osborne		
DOB	18-Feb-1934		
NHS No.	138794377		
Address	127 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice

Screening Questi	ons (FOR COMP	LETION BY PATII	ENT)	Yes	No	
If you answer YES discuss with your	_	questions, or are	e unsure, please			
1. Are you feeling unantibiotics?	nwell today, for ex	ample, a high tem	perature or are			
2. Do you suffer from severe allergies, or have have ever had a severe allergic reaction?						
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?						
Consent FOR COMPLETIO	ON IN THE EVENT OF AN	I IT OUTAGE				
Consent given?	Yes No					
Consent Provided By:	Patient LPA for Health	n Court Appointed Depu	uty Clinician Best Interests Decisi	ion (MCA)		
Vaccination Details FOR (COMPLETION IN THE EV	ENT OF AN IT OUTAGE				
Dose Round			First			
Time of Vaccination (24hr)		09:10	Date of Vaccination 20/		021	
Vaccine Brand and Batch Number						
Administration Site		Left Right Deltoid Thigh				
Any Adverse Effects (blank for none) or other comments						
Vaccinator Name						
Vaccine not given (reason)			Unwell Contraindicated Did not consent			

6 of 23

Vaccine Record Form

Vaccinator Name

Vaccine not given (reason)

Name	Percy Macgregor	国際第回 95年的影響		
DOB	20-Mar-1951			
NHS No.	684496401			
Address	128 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice	

Address	128 Test S	Street, Bedford, BD12 3AD GP Practice Test General Medical Practice						
Screening Questions (FOR COMPLETION BY PATIENT) If you answer YES to any of these questions, or are unsure, please discuss with your vaccinator							Yes	No
1. Are you feeling unwell today, for example, a high temperature or are antibiotics?								
2. Do you suffer from severe allergies, or have have ever had a severe allergic reaction?								
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?								
Consent FOR	COMPLETIC	ON IN THE EVENT OF A	N IT OUTAGE					
Consent given	?	Yes No						
Consent Provid	ded By:	Patient LPA for HealtI	n Court Appointe	ed Deputy Clii	nician E	Best Interests Decisi	on (MCA)	
Vaccination D	etails FOR (COMPLETION IN THE EV	/ENT OF AN IT O	UTAGE				
Dose Round First								
Time of Vaccination (24hr) 09:20			Date	Date of Vaccination 20/01/2021			021	
Vaccine Brand and Batch Number								
Administration Site Left Right Deltoid Thigh								
Any Adverse Effects (blank for none) or other comments								

7 of 23

Vaccine Record Form

Vaccinator Name

Vaccine not given (reason)

Name	Momina Ellis	回:: 张 国 4(5)(5)(4)(5)		
DOB	21-Sep-1977			
NHS No.	280602999			
Address	129 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice	

Address	129 Test S	Street, Bedford, BD12 3AD GP Practice Test General Medical Practice						
Screening Questions (FOR COMPLETION BY PATIENT)						Yes	No	
If you answer YES to any of these questions, or are unsure, please discuss with your vaccinator								
1. Are you feeling unwell today, for example, a high temperature or are antibiotics?								
2. Do you suffer from severe allergies, or have have ever had a severe allergic reaction?								
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?								
Consent FOR	COMPLETIC	ON IN THE EVENT OF AN	I IT OUTAGE					
Consent given	?	Yes No						
Consent Provid	ded By:	Patient LPA for Health	n Court Appointe	ed Deputy Cli	inician B	est Interests Decision	on (MCA)	
Vaccination D	etails FOR (COMPLETION IN THE EV	ENT OF AN IT O	UTAGE				
Dose Round				First				
Time of Vaccination (24hr) 09:30			Date	Date of Vaccination 20/01/2021			021	
Vaccine Brand and Batch Number								
Administration Site Left Right Deltoid Thigh								
Any Adverse Effects (blank for none) or other comments								

8 of 23

Vaccine Record Form

Vaccine not given (reason)

Name	Dottie Cooper			
DOB	2-Dec-1988			
NHS No.	696014651			
Address	130 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice	

Screening Question	Yes	No					
If you answer YES discuss with your							
1. Are you feeling un antibiotics?							
2. Do you suffer from severe allergies, or have have ever had a severe allergic reaction?							
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?							
Consent FOR COMPLETIO	ON IN THE EVENT OF AI	N IT OUTAGE					
Consent given?	Yes No						
Consent Provided By:	Patient LPA for Healt	h Court Appointed Depu	uty Clinician Best Interests Decisi	on (MCA)			
Vaccination Details FOR C	COMPLETION IN THE EV	VENT OF AN IT OUTAGE	:				
Dose Round			First				
Time of Vaccination (24hr) 09:40			Date of Vaccination 20/01/2021				
Vaccine Brand and Batch N	lumber						
Administration Site		Left Right Deltoid Thigh					
Any Adverse Effects (blank	for none) or other comn						
Vaccinator Name							

9 of 23 13/01/2025, 18:07

Vaccine Record Form

Vaccine not given (reason)

Name	Loretta Mustafa			
DOB	30-Aug-1986			
NHS No.	999596593			
Address	131 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice	

7.00.000		G. 1	1401100	Took Contoral Wicale	41114414	
Screening Questions (FOR COMPLETION BY PATIENT)						No
If you answer YES	please					
1. Are you feeling unwell today, for example, a high temperature or are antibiotics?						
2. Do you suffer from severe allergies, or have have ever had a severe allergic reaction?						
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?						
Consent FOR COMPLETION	ON IN THE EVENT OF A	N IT OUTAGE				
Consent given?	Yes No					
Consent Provided By:	Patient LPA for Healt	h Court Appointed Dep	outy Clinician E	Best Interests Decisio	n (MCA)	
Vaccination Details FOR	COMPLETION IN THE E	VENT OF AN IT OUTAG	E			
Dose Round			First			
Time of Vaccination (24hr) 09:50			Date of Vaccination 20/01/2021			
Vaccine Brand and Batch I						
Administration Site	Left Right	Deltoid Thigh				
Any Adverse Effects (blank for none) or other comments						
Vaccinator Name						

10 of 23 13/01/2025, 18:07

Vaccine Record Form

Vaccine not given (reason)

Name	Abby Millington			
DOB	20-Aug-1996			
NHS No.	688948191			
Address	132 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice	

7.00.000	.02 .000			G. 1.464.65	1001 00110101111100110				
Screening (Questic	ons (FOR COMPI	LETION BY	PATIENT)		Yes	No		
If you answ discuss wit									
1. Are you feeling unwell today, for example, a high temperature or are antibiotics?									
2. Do you suffer from severe allergies, or have have ever had a severe allergic reaction?									
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?									
Consent FOR CO	OMPLETIO	N IN THE EVENT OF AN	IT OUTAGE						
Consent given?		Yes No							
Consent Provided	d By:	Patient LPA for Health	Court Appointe	ed Deputy Clinician I	Best Interests Decision	on (MCA)			
Vaccination Deta	ails FOR C	COMPLETION IN THE EV	ENT OF AN IT O	UTAGE					
Dose Round				First	First				
Time of Vaccination (24hr) 10:00			Date of Vac	Date of Vaccination 20/01/2021					
Vaccine Brand and Batch Number									
Administration Site Lef				Left Right	Deltoid Thigh				
Any Adverse Effects (blank for none) or other comments									
Vaccinator Name									

11 of 23 13/01/2025, 18:07

Vaccine Record Form

Vaccinator Name

Vaccine not given (reason)

Name	Reeva Smith	© 255 © N3Sekit24		
DOB	17-Nov-1928			
NHS No.	371062034			
Address	133 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice	

Address	133 Test S	treet, Bedford, BD12 3AD GP Practice Test General Medical Practice						
Screening	Screening Questions (FOR COMPLETION BY PATIENT)						Yes	No
If you answer YES to any of these questions, or are unsure, please discuss with your vaccinator								
1. Are you feeling unwell today, for example, a high temperature or are antibiotics?								
2. Do you suffer from severe allergies, or have have ever had a severe allergic reaction?								
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?								
Consent FOR	COMPLETIC	ON IN THE EVENT OF AN	IT OUTAGE					
Consent given	?	Yes No						
Consent Provid	ded By:	Patient LPA for Health	Court Appointe	ed Deputy	Clinician E	Best Interests Decisi	on (MCA)	
Vaccination D	etails FOR C	COMPLETION IN THE EVE	ENT OF AN IT O	UTAGE				
Dose Round				F	First			
Time of Vaccination (24hr) 10:10			I	Date of Vaccination 20/01/2021			021	
Vaccine Brand and Batch Number								
Administration Site Left Right Deltoid Thigh								
Any Adverse Effects (blank for none) or other comments								

12 of 23 13/01/2025, 18:07

Vaccine Record Form

Vaccinator Name

Vaccine not given (reason)

Name	Anne Whitmore			
DOB	25-Nov-1930			
NHS No.	722063876			
Address	134 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice	

Addiess	104 1650 0	Street, Bedford, BD12 3AD OF Fractice Test General Medical Fractice					
Screening Questions (FOR COMPLETION BY PATIENT)						Yes	No
If you answer YES to any of these questions, or are unsure, please discuss with your vaccinator							
1. Are you feeling unwell today, for example, a high temperature or are antibiotics?							
2. Do you suffer from severe allergies, or have have ever had a severe allergic reaction?							
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?							
Consent FOR C	OMPLETIO	ON IN THE EVENT OF AN	IT OUTAGE				
Consent For C	OWIPELITO	IN IN THE EVENT OF AN	TI OUTAGE				
Consent given?		Yes No					
Consent Provide	ed By:	Patient LPA for Health	Court Appoint	ed Deputy Clinician E	Best Interests Decision	on (MCA)	
Vaccination De	staile FOR C	OMPLETION IN THE EV	ENT OF AN IT O	NITACE			
vaccination De	etalis FOR C	OMPLETION IN THE EV	ENT OF ANTI C	JUTAGE			
Dose Round				First			
Time of Vaccination (24hr) 10:20 Date of Vaccination				cination	20/01/20	021	
Vaccine Brand and Batch Number							
Administration Site Left Right Deltoid Thigh				Deltoid Thigh			
Any Adverse Effects (blank for none) or other comments							

13 of 23 13/01/2025, 18:07

Vaccine Record Form

Vaccinator Name

Vaccine not given (reason)

Name	Kris Fields			
DOB	7-Dec-1944			
NHS No.	151432123			
Address	135 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice	

Address	135 Test S	GP Practice Test General Medical Practice						
Screening Questions (FOR COMPLETION BY PATIENT)						Yes	No	
If you answer YES to any of these questions, or are unsure, please discuss with your vaccinator								
1. Are you feeling unwell today, for example, a high temperature or are antibiotics?								
2. Do you suffer from severe allergies, or have have ever had a severe allergic reaction?								
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?								
Consent FOR	COMPLETIC	ON IN THE EVENT OF AN	I IT OUTAGE					
Consent given?	?	Yes No						
Consent Provid	ded By:	Patient LPA for Health	ı Court Appoint	ed Deputy Clinic	ian Best Interests Decis	ion (MCA)		
Vaccination D	etails FOR C	COMPLETION IN THE EV	ENT OF AN IT C	OUTAGE				
Dose Round				First				
Time of Vaccination (24hr) 10:30 Date of Vaccination				Vaccination	20/01/2	021		
Vaccine Brand and Batch Number								
Administration Site Left Right Deltoid Thigh								
Any Adverse Effects (blank for none) or other comments								

14 of 23 13/01/2025, 18:07

Vaccine Record Form

Vaccinator Name

Vaccine not given (reason)

Name	Sabrina Hampton	回答公司 35535433		
DOB	2-Nov-1978			
NHS No.	41337996			
Address	136 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice	

Address	136 lest S	treet, Bedford, BD12 3AD GP Practice Test General Medical Practice						
Screening Questions (FOR COMPLETION BY PATIENT)						Yes	No	
If you answer YES to any of these questions, or are unsure, please discuss with your vaccinator								
1. Are you antibiotics		nwell today, for exa	ample, a hig	ıh tempera	ature oi	r are		
2. Do you suffer from severe allergies, or have have ever had a severe allergic reaction?						vere allergic		
3. Have yo vaccinatio		y severe side effe	cts from pre	vious Cov	vid and,	or Flu		
Consent FOR	COMPLETIC	ON IN THE EVENT OF AN	IT OUTAGE					
Consent given	?	Yes No						
Consent Provid	ded By:	Patient LPA for Health	Court Appointe	ed Deputy Cl	linician Be	est Interests Decisi	on (MCA)	
Vaccination D	etails FOR C	COMPLETION IN THE EV	ENT OF AN IT O	UTAGE				
Dose Round				Firs	t			
Time of Vaccination (24hr) 10:40 Date of Vaccination					nation	20/01/20	021	
Vaccine Brand and Batch Number								
Administration Site Left Right Deltoid Thigh								
Any Adverse Effects (blank for none) or other comments								

15 of 23 13/01/2025, 18:07

Vaccine Record Form

Vaccinator Name

Vaccine not given (reason)

Name	Ethel Knapp			
DOB	21-Jul-1929			
NHS No.	90079148			
Address	137 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice	

Address	137 Test S	treet, Bedford, BD12 3AD GP Practice Test General Medical Practice						
Screening Questions (FOR COMPLETION BY PATIENT)						Yes	No	
If you answer YES to any of these questions, or are unsure, please discuss with your vaccinator								
1. Are you feeling unwell today, for example, a high temperature or are antibiotics?								
2. Do you suffer from severe allergies, or have have ever had a severe allergic reaction?								
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?								
Consent FOR	COMPLETIC	ON IN THE EVENT OF AN	I IT OUTAGE					
Consent given?	?	Yes No						
Consent Provid	led By:	Patient LPA for Health	Court Appoint	ed Deputy Clinician	Best Interests Decision	on (MCA)		
Vaccination D	etails FOR C	COMPLETION IN THE EV	ENT OF AN IT C	DUTAGE				
Dose Round				First				
Time of Vaccination (24hr) 10:50 Date of Vaccination				ccination	20/01/2	021		
Vaccine Brand and Batch Number								
Administration Site Left Right Deltoid Thigh								
Any Adverse Effects (blank for none) or other comments								

16 of 23 13/01/2025, 18:07

Vaccine Record Form

Vaccinator Name

Vaccine not given (reason)

Name	Nel Bishop			
DOB	17-Mar-1965			
NHS No.	380315136			
Address	138 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice	

Address	138 Test S	GP Practice Test General Medical Practice						
Screening Questions (FOR COMPLETION BY PATIENT)						Yes	No	
If you answer YES to any of these questions, or are unsure, please discuss with your vaccinator								
1. Are you feeling unwell today, for example, a high temperature or are antibiotics?								
2. Do you suffer from severe allergies, or have have ever had a severe allergic reaction?								
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?								
Consent FOR	COMPLETIC	ON IN THE EVENT OF AN	IT OUTAGE					
Consent given?	?	Yes No						
Consent Provid	led By:	Patient LPA for Health	Court Appointe	ed Deputy Clinician	Best Interests Decision	on (MCA)		
Vaccination De	etails FOR C	COMPLETION IN THE EVE	ENT OF AN IT O	UTAGE				
Dose Round				First				
Time of Vaccination (24hr) 11:00 Date of Vaccination				cination	20/01/20	021		
Vaccine Brand and Batch Number								
Administration Site Left Right Deltoid Thigh								
Any Adverse Effects (blank for none) or other comments								

17 of 23 13/01/2025, 18:07

Vaccine Record Form

Vaccinator Name

Vaccine not given (reason)

Name	Matt Owens		
DOB	25-Mar-1968		
NHS No.	739687046		
Address	139 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice

Address	139 Test S	Street, Bedford, BD12 3AD GP Practice Test General Medical Practice					
Screening Questions (FOR COMPLETION BY PATIENT) If you answer YES to any of these questions, or are unsure, please discuss with your vaccinator							No
1. Are you feeling unwell today, for example, a high temperature or are antibiotics?							
2. Do you suffer from severe allergies, or have have ever had a severe allergic reaction?							
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?							
Consent FOR	COMPLETIC	ON IN THE EVENT OF AN I	T OUTAGE				
Consent given	?	Yes No					
Consent Provid	ded By:	Patient LPA for Health	Court Appointe	d Deputy Clini	cian Best Interests Dec	cision (MCA)	
Vaccination D	etails FOR (COMPLETION IN THE EVE	NT OF AN IT O	JTAGE			
Dose Round				First			
Time of Vaccination (24hr) 11:10 Date of Vaccination				f Vaccination	20/01/2	021	
Vaccine Brand	and Batch N	lumber					
Administration Site Left Right Deltoid Thigh							
Any Adverse Effects (blank for none) or other comments							

18 of 23 13/01/2025, 18:07

Vaccine Record Form

Vaccinator Name

Vaccine not given (reason)

Name	Jimmy Connelly			
DOB	17-Jun-1958			
NHS No.	756766738			
Address	140 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice	

Address	140 Test S	street, Bedford, BD12 3AD		GP Practice	Practice Test General Medical Practice				
Screening Questions (FOR COMPLETION BY PATIENT)						Yes	No		
If you answer YES to any of these questions, or are unsure, please discuss with your vaccinator									
1. Are you feeling unwell today, for example, a high temperature or are antibiotics?									
2. Do you suffer from severe allergies, or have have ever had a severe allergic reaction?									
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?									
Consent FOR	COMPLETIC	ON IN THE EVENT OF AN	IT OUTAGE						
Consent given	?	Yes No							
Consent Provid	ded By:	Patient LPA for Health	Court Appointe	ed Deputy Clinician	Best Interests Decision	on (MCA)			
Vaccination D	etails FOR (COMPLETION IN THE EVE	ENT OF AN IT O	UTAGE					
Dose Round First									
Time of Vaccination (24hr) 11:20			Date of Va	Date of Vaccination 20/01/2021					
Vaccine Brand and Batch Number									
Administration Site				Left Right	Left Right Deltoid Thigh				
Any Adverse Effects (blank for none) or other comments									

19 of 23 13/01/2025, 18:07

Vaccine Record Form

Vaccinator Name

Vaccine not given (reason)

Name	Leona Witt		回為第回 (1967年8月	
DOB	13-Dec-1970			
NHS No.	900679219			
Address	141 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice	

		0		1001 001101 0110101			
Screening Question	ons (FOR COMPL	ETION BY PAT	IENT)		Yes	No	
If you answer YES discuss with your	please						
1. Are you feeling unwell today, for example, a high temperature or are antibiotics?							
2. Do you suffer from severe allergies, or have have ever had a severe allergic reaction?							
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?							
Consent FOR COMPLETIO	ON IN THE EVENT OF AN	IT OUTAGE					
Consent given?	Yes No						
Consent Provided By:	Patient LPA for Health	Court Appointed Dep	uty Clinician	Best Interests Decision	on (MCA)		
Vaccination Details FOR C	OMPLETION IN THE EVE	ENT OF AN IT OUTAG	E				
Dose Round			First				
Time of Vaccination (24hr) 11:30			Date of Vaccination 20/01/2021			021	
Vaccine Brand and Batch Number							
Administration Site				Left Right Deltoid Thigh			
Any Adverse Effects (blank	for none) or other comme	ents					

20 of 23 13/01/2025, 18:07

Vaccine Record Form

Vaccinator Name

Vaccine not given (reason)

Name	Karina Rowland		国際新国 SISEE SEN	
DOB	29-Aug-1948			
NHS No.	349888464			
Address	142 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice	

Address	142 Test S	GP Practice Test General Medical Practice						
Screening	Screening Questions (FOR COMPLETION BY PATIENT)						Yes	No
If you answer YES to any of these questions, or are unsure, please discuss with your vaccinator								
1. Are you feeling unwell today, for example, a high temperature or are antibiotics?								
2. Do you suffer from severe allergies, or have have ever had a severe allergic reaction?								
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?					d/or Flu			
Consent FOR	COMPLETIO	N IN THE EVENT OF AN	IT OUTAGE					
Consent given	?	Yes No						
Consent Provid	ded By:	Patient LPA for Health	Court Appointe	ed Deput	ty Clinician I	Best Interests Decision	on (MCA)	
Vaccination D	etails FOR C	OMPLETION IN THE EVE	ENT OF AN IT O	UTAGE				
Dose Round					First			
Time of Vaccination (24hr) 11:40				Date of Vaccination 20/01/2021			021	
Vaccine Brand and Batch Number								
Administration Site					Left Right Deltoid Thigh			
Any Adverse Effects (blank for none) or other comments								

21 of 23 13/01/2025, 18:07

Vaccine Record Form

Vaccinator Name

Vaccine not given (reason)

Name	Neave Yang			
DOB	30-Jan-1924			
NHS No.	835258980			
Address	143 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice	

Address	145 1650 5	tieet, bealora, bb12 3Ab		OF FIAC	Juce	rest General Medi	cai Fractice	
Screening Questions (FOR COMPLETION BY PATIENT)							Yes	No
If you answer YES to any of these questions, or are unsure, please discuss with your vaccinator								
1. Are you feeling unwell today, for example, a high temperature or are antibiotics?								
2. Do you suffer from severe allergies, or have have ever had a severe allergic reaction?					evere allergic			
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?					d/or Flu			
Consent FOR C	COMPLETIO	N IN THE EVENT OF AN	IT OUTAGE					
Consent given?	•	Yes No						
Consent Provid	ed By:	Patient LPA for Health	Court Appointe	ed Deputy	/ Clinician E	Best Interests Decision	on (MCA)	
Vaccination De	etails FOR C	OMPLETION IN THE EVE	ENT OF AN IT O	UTAGE				
Dose Round					First			
Time of Vaccination (24hr) 11:50				Date of Vaccination 20/01/2021			021	
Vaccine Brand and Batch Number								
Administration Site					Left Right Deltoid Thigh			
Any Adverse Effects (blank for none) or other comments								

22 of 23 13/01/2025, 18:07

Vaccine Record Form

Vaccinator Name

Vaccine not given (reason)

Name	Bartosz Murphy		■\$35 ■ 224 7 G 3	
DOB	31-Oct-1942	17646 (253 ■ 8878 (3		
NHS No.	451757567			
Address	144 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice	

Address	144 Test S	treet, Bedford, BD12 3AD		GP Practice	P Practice Test General Medical Practice				
Screening Questions (FOR COMPLETION BY PATIENT)						Yes	No		
If you answer YES to any of these questions, or are unsure, please discuss with your vaccinator									
1. Are you feeling unwell today, for example, a high temperature or are antibiotics?									
2. Do you suffer from severe allergies, or have have ever had a severe allergic reaction?									
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?									
Consent FOR	COMPLETIC	ON IN THE EVENT OF AN	IT OUTAGE						
Consent given	?	Yes No							
Consent Provid	ded By:	Patient LPA for Health	Court Appointe	ed Deputy Clinic	ian Best Interests Decis	sion (MCA)			
Vaccination D	etails FOR C	COMPLETION IN THE EVI	ENT OF AN IT O	OUTAGE					
Dose Round First									
Time of Vaccination (24hr) 12:00			Date of	Date of Vaccination 20/01/2021					
Vaccine Brand and Batch Number									
Administration Site				Left Ri	Left Right Deltoid Thigh				
Any Adverse Effects (blank for none) or other comments									

23 of 23 13/01/2025, 18:07