Vaccine Record Form

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

Screening Questions (FOR COMPLETION BY PATIENT)	**Yes**	**No**
1. What is your age .....?		
2. If under 65yrs please give reason for vaccination.....		
3. Are you severely immunosuppressed? If so please give reason .....?		
4. Do you have a history of anaphylaxis or significant allergic reaction to any vaccine or its ingredients?		
5. Do you have an egg allergy?		
6. Have you experienced any serious adverse reacion after previous COVID-19 or Influenza vaccinations?		
7. Are you suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for vaccination)?		
8. Are you taking anticoagulant medication, or do you have a bleeding disorder?		
9. Are you or could you be pregnant?		
10. Have you had a COVID vaccine related to Myocarditis or Pericarditis related to a previous Covid vaccination?		

Consent FOR COMPLETION IN THE EVENT OF AN IT OUTAGE	
Consent given?	Yes | No
Consent Provided By:	Patient | LPA for Health | Court Appointed Deputy | Clinician Best Interests Decision (MCA)

Vaccination Details FOR COMPLETION IN THE EVENT 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			
Vaccine not given (reason)		Unwell | Contraindicated | Did not consent	

Vaccine Record Form

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

Screening Questions (FOR COMPLETION BY PATIENT)	**Yes**	**No**
1. What is your age .....?		
2. If under 65yrs please give reason for vaccination.....		
3. Are you severely immunosuppressed? If so please give reason .....?		
4. Do you have a history of anaphylaxis or significant allergic reaction to any vaccine or its ingredients?		
5. Do you have an egg allergy?		
6. Have you experienced any serious adverse reacion after previous COVID-19 or Influenza vaccinations?		
7. Are you suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for vaccination)?		
8. Are you taking anticoagulant medication, or do you have a bleeding disorder?		
9. Are you or could you be pregnant?		
10. Have you had a COVID vaccine related to Myocarditis or Pericarditis related to a previous Covid vaccination?		

Consent FOR COMPLETION IN THE EVENT OF AN IT OUTAGE	
Consent given?	Yes | No
Consent Provided By:	Patient | LPA for Health | Court Appointed Deputy | Clinician Best Interests Decision (MCA)

Vaccination Details FOR COMPLETION IN THE EVENT OF AN IT OUTAGE			
Dose Round		First	
Time of Vaccination (24hr)	08:40	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			
Vaccine not given (reason)		Unwell | Contraindicated | Did not consent	

Vaccine Record Form

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)	**Yes**	**No**
1. What is your age .....?		
2. If under 65yrs please give reason for vaccination.....		
3. Are you severely immunosuppressed? If so please give reason .....?		
4. Do you have a history of anaphylaxis or significant allergic reaction to any vaccine or its ingredients?		
5. Do you have an egg allergy?		
6. Have you experienced any serious adverse reacion after previous COVID-19 or Influenza vaccinations?		
7. Are you suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for vaccination)?		
8. Are you taking anticoagulant medication, or do you have a bleeding disorder?		
9. Are you or could you be pregnant?		
10. Have you had a COVID vaccine related to Myocarditis or Pericarditis related to a previous Covid vaccination?		

Consent FOR COMPLETION IN THE EVENT OF AN IT OUTAGE	
Consent given?	Yes | No
Consent Provided By:	Patient | LPA for Health | Court Appointed Deputy | Clinician Best Interests Decision (MCA)

Vaccination Details FOR COMPLETION IN THE EVENT OF AN IT OUTAGE			
Dose Round		First	
Time of Vaccination (24hr)	08:50	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			
Vaccine not given (reason)		Unwell | Contraindicated | Did not consent	

Vaccine Record Form

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

Screening Questions (FOR COMPLETION BY PATIENT)	**Yes**	**No**
1. What is your age .....?		
2. If under 65yrs please give reason for vaccination.....		
3. Are you severely immunosuppressed? If so please give reason .....?		
4. Do you have a history of anaphylaxis or significant allergic reaction to any vaccine or its ingredients?		
5. Do you have an egg allergy?		
6. Have you experienced any serious adverse reacion after previous COVID-19 or Influenza vaccinations?		
7. Are you suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for vaccination)?		
8. Are you taking anticoagulant medication, or do you have a bleeding disorder?		
9. Are you or could you be pregnant?		
10. Have you had a COVID vaccine related to Myocarditis or Pericarditis related to a previous Covid vaccination?		

Consent FOR COMPLETION IN THE EVENT OF AN IT OUTAGE	
Consent given?	Yes | No
Consent Provided By:	Patient | LPA for Health | Court Appointed Deputy | Clinician Best Interests Decision (MCA)

Vaccination Details FOR COMPLETION IN THE EVENT OF AN IT OUTAGE			
Dose Round		First	
Time of Vaccination (24hr)	09:00	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			
Vaccine not given (reason)		Unwell | Contraindicated | Did not consent	

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 Questions (FOR COMPLETION BY PATIENT)	**Yes**	**No**
1. What is your age .....?		
2. If under 65yrs please give reason for vaccination.....		
3. Are you severely immunosuppressed? If so please give reason .....?		
4. Do you have a history of anaphylaxis or significant allergic reaction to any vaccine or its ingredients?		
5. Do you have an egg allergy?		
6. Have you experienced any serious adverse reacion after previous COVID-19 or Influenza vaccinations?		
7. Are you suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for vaccination)?		
8. Are you taking anticoagulant medication, or do you have a bleeding disorder?		
9. Are you or could you be pregnant?		
10. Have you had a COVID vaccine related to Myocarditis or Pericarditis related to a previous Covid vaccination?		

Consent FOR COMPLETION IN THE EVENT OF AN IT OUTAGE	
Consent given?	Yes | No
Consent Provided By:	Patient | LPA for Health | Court Appointed Deputy | Clinician Best Interests Decision (MCA)

Vaccination Details FOR COMPLETION IN THE EVENT OF AN IT OUTAGE			
Dose Round		First	
Time of Vaccination (24hr)	09:10	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			
Vaccine not given (reason)		Unwell | Contraindicated | Did not consent	

Vaccine Record Form

Name	Percy Macgregor		
DOB	20-Mar-1951		
NHS No.	684496401		
Address	128 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice

Screening Questions (FOR COMPLETION BY PATIENT)	**Yes**	**No**
1. What is your age .....?		
2. If under 65yrs please give reason for vaccination.....		
3. Are you severely immunosuppressed? If so please give reason .....?		
4. Do you have a history of anaphylaxis or significant allergic reaction to any vaccine or its ingredients?		
5. Do you have an egg allergy?		
6. Have you experienced any serious adverse reacion after previous COVID-19 or Influenza vaccinations?		
7. Are you suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for vaccination)?		
8. Are you taking anticoagulant medication, or do you have a bleeding disorder?		
9. Are you or could you be pregnant?		
10. Have you had a COVID vaccine related to Myocarditis or Pericarditis related to a previous Covid vaccination?		

Consent FOR COMPLETION IN THE EVENT OF AN IT OUTAGE	
Consent given?	Yes | No
Consent Provided By:	Patient | LPA for Health | Court Appointed Deputy | Clinician Best Interests Decision (MCA)

Vaccination Details FOR COMPLETION IN THE EVENT OF AN IT OUTAGE			
Dose Round		First	
Time of Vaccination (24hr)	09:20	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			
Vaccine not given (reason)		Unwell | Contraindicated | Did not consent	

Vaccine Record Form

Name	Momina Ellis		
DOB	21-Sep-1977		
NHS No.	280602999		
Address	129 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice

Screening Questions (FOR COMPLETION BY PATIENT)	**Yes**	**No**
1. What is your age .....?		
2. If under 65yrs please give reason for vaccination.....		
3. Are you severely immunosuppressed? If so please give reason .....?		
4. Do you have a history of anaphylaxis or significant allergic reaction to any vaccine or its ingredients?		
5. Do you have an egg allergy?		
6. Have you experienced any serious adverse reacion after previous COVID-19 or Influenza vaccinations?		
7. Are you suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for vaccination)?		
8. Are you taking anticoagulant medication, or do you have a bleeding disorder?		
9. Are you or could you be pregnant?		
10. Have you had a COVID vaccine related to Myocarditis or Pericarditis related to a previous Covid vaccination?		

Consent FOR COMPLETION IN THE EVENT OF AN IT OUTAGE	
Consent given?	Yes | No
Consent Provided By:	Patient | LPA for Health | Court Appointed Deputy | Clinician Best Interests Decision (MCA)

Vaccination Details FOR COMPLETION IN THE EVENT OF AN IT OUTAGE			
Dose Round		First	
Time of Vaccination (24hr)	09:30	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			
Vaccine not given (reason)		Unwell | Contraindicated | Did not consent	

Vaccine Record Form

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

Screening Questions (FOR COMPLETION BY PATIENT)	**Yes**	**No**
1. What is your age .....?		
2. If under 65yrs please give reason for vaccination.....		
3. Are you severely immunosuppressed? If so please give reason .....?		
4. Do you have a history of anaphylaxis or significant allergic reaction to any vaccine or its ingredients?		
5. Do you have an egg allergy?		
6. Have you experienced any serious adverse reacion after previous COVID-19 or Influenza vaccinations?		
7. Are you suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for vaccination)?		
8. Are you taking anticoagulant medication, or do you have a bleeding disorder?		
9. Are you or could you be pregnant?		
10. Have you had a COVID vaccine related to Myocarditis or Pericarditis related to a previous Covid vaccination?		

Consent FOR COMPLETION IN THE EVENT OF AN IT OUTAGE	
Consent given?	Yes | No
Consent Provided By:	Patient | LPA for Health | Court Appointed Deputy | Clinician Best Interests Decision (MCA)

Vaccination Details FOR COMPLETION IN THE EVENT OF AN IT OUTAGE			
Dose Round		First	
Time of Vaccination (24hr)	09:40	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			
Vaccine not given (reason)		Unwell | Contraindicated | Did not consent	

Vaccine Record Form

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

Screening Questions (FOR COMPLETION BY PATIENT)	**Yes**	**No**
1. What is your age .....?		
2. If under 65yrs please give reason for vaccination.....		
3. Are you severely immunosuppressed? If so please give reason .....?		
4. Do you have a history of anaphylaxis or significant allergic reaction to any vaccine or its ingredients?		
5. Do you have an egg allergy?		
6. Have you experienced any serious adverse reacion after previous COVID-19 or Influenza vaccinations?		
7. Are you suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for vaccination)?		
8. Are you taking anticoagulant medication, or do you have a bleeding disorder?		
9. Are you or could you be pregnant?		
10. Have you had a COVID vaccine related to Myocarditis or Pericarditis related to a previous Covid vaccination?		

Consent FOR COMPLETION IN THE EVENT OF AN IT OUTAGE	
Consent given?	Yes | No
Consent Provided By:	Patient | LPA for Health | Court Appointed Deputy | Clinician Best Interests Decision (MCA)

Vaccination Details FOR COMPLETION IN THE EVENT OF AN IT OUTAGE			
Dose Round		First	
Time of Vaccination (24hr)	09:50	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			
Vaccine not given (reason)		Unwell | Contraindicated | Did not consent	

Vaccine Record Form

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

Screening Questions (FOR COMPLETION BY PATIENT)	**Yes**	**No**
1. What is your age .....?		
2. If under 65yrs please give reason for vaccination.....		
3. Are you severely immunosuppressed? If so please give reason .....?		
4. Do you have a history of anaphylaxis or significant allergic reaction to any vaccine or its ingredients?		
5. Do you have an egg allergy?		
6. Have you experienced any serious adverse reacion after previous COVID-19 or Influenza vaccinations?		
7. Are you suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for vaccination)?		
8. Are you taking anticoagulant medication, or do you have a bleeding disorder?		
9. Are you or could you be pregnant?		
10. Have you had a COVID vaccine related to Myocarditis or Pericarditis related to a previous Covid vaccination?		

Consent FOR COMPLETION IN THE EVENT OF AN IT OUTAGE	
Consent given?	Yes | No
Consent Provided By:	Patient | LPA for Health | Court Appointed Deputy | Clinician Best Interests Decision (MCA)

Vaccination Details FOR COMPLETION IN THE EVENT OF AN IT OUTAGE			
Dose Round		First	
Time of Vaccination (24hr)	10:00	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			
Vaccine not given (reason)		Unwell | Contraindicated | Did not consent	

Vaccine Record Form

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

Screening Questions (FOR COMPLETION BY PATIENT)	**Yes**	**No**
1. What is your age .....?		
2. If under 65yrs please give reason for vaccination.....		
3. Are you severely immunosuppressed? If so please give reason .....?		
4. Do you have a history of anaphylaxis or significant allergic reaction to any vaccine or its ingredients?		
5. Do you have an egg allergy?		
6. Have you experienced any serious adverse reacion after previous COVID-19 or Influenza vaccinations?		
7. Are you suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for vaccination)?		
8. Are you taking anticoagulant medication, or do you have a bleeding disorder?		
9. Are you or could you be pregnant?		
10. Have you had a COVID vaccine related to Myocarditis or Pericarditis related to a previous Covid vaccination?		

Consent FOR COMPLETION IN THE EVENT OF AN IT OUTAGE	
Consent given?	Yes | No
Consent Provided By:	Patient | LPA for Health | Court Appointed Deputy | Clinician Best Interests Decision (MCA)

Vaccination Details FOR COMPLETION IN THE EVENT OF AN IT OUTAGE			
Dose Round		First	
Time of Vaccination (24hr)	10:10	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			
Vaccine not given (reason)		Unwell | Contraindicated | Did not consent	

Vaccine Record Form

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

Screening Questions (FOR COMPLETION BY PATIENT)	**Yes**	**No**
1. What is your age .....?		
2. If under 65yrs please give reason for vaccination.....		
3. Are you severely immunosuppressed? If so please give reason .....?		
4. Do you have a history of anaphylaxis or significant allergic reaction to any vaccine or its ingredients?		
5. Do you have an egg allergy?		
6. Have you experienced any serious adverse reacion after previous COVID-19 or Influenza vaccinations?		
7. Are you suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for vaccination)?		
8. Are you taking anticoagulant medication, or do you have a bleeding disorder?		
9. Are you or could you be pregnant?		
10. Have you had a COVID vaccine related to Myocarditis or Pericarditis related to a previous Covid vaccination?		

Consent FOR COMPLETION IN THE EVENT OF AN IT OUTAGE	
Consent given?	Yes | No
Consent Provided By:	Patient | LPA for Health | Court Appointed Deputy | Clinician Best Interests Decision (MCA)

Vaccination Details FOR COMPLETION IN THE EVENT OF AN IT OUTAGE			
Dose Round		First	
Time of Vaccination (24hr)	10:20	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			
Vaccine not given (reason)		Unwell | Contraindicated | Did not consent	

Vaccine Record Form

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

Screening Questions (FOR COMPLETION BY PATIENT)	**Yes**	**No**
1. What is your age .....?		
2. If under 65yrs please give reason for vaccination.....		
3. Are you severely immunosuppressed? If so please give reason .....?		
4. Do you have a history of anaphylaxis or significant allergic reaction to any vaccine or its ingredients?		
5. Do you have an egg allergy?		
6. Have you experienced any serious adverse reacion after previous COVID-19 or Influenza vaccinations?		
7. Are you suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for vaccination)?		
8. Are you taking anticoagulant medication, or do you have a bleeding disorder?		
9. Are you or could you be pregnant?		
10. Have you had a COVID vaccine related to Myocarditis or Pericarditis related to a previous Covid vaccination?		

Consent FOR COMPLETION IN THE EVENT OF AN IT OUTAGE	
Consent given?	Yes | No
Consent Provided By:	Patient | LPA for Health | Court Appointed Deputy | Clinician Best Interests Decision (MCA)

Vaccination Details FOR COMPLETION IN THE EVENT OF AN IT OUTAGE			
Dose Round		First	
Time of Vaccination (24hr)	10:30	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			
Vaccine not given (reason)		Unwell | Contraindicated | Did not consent	

Vaccine Record Form

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

Screening Questions (FOR COMPLETION BY PATIENT)	**Yes**	**No**
1. What is your age .....?		
2. If under 65yrs please give reason for vaccination.....		
3. Are you severely immunosuppressed? If so please give reason .....?		
4. Do you have a history of anaphylaxis or significant allergic reaction to any vaccine or its ingredients?		
5. Do you have an egg allergy?		
6. Have you experienced any serious adverse reacion after previous COVID-19 or Influenza vaccinations?		
7. Are you suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for vaccination)?		
8. Are you taking anticoagulant medication, or do you have a bleeding disorder?		
9. Are you or could you be pregnant?		
10. Have you had a COVID vaccine related to Myocarditis or Pericarditis related to a previous Covid vaccination?		

Consent FOR COMPLETION IN THE EVENT OF AN IT OUTAGE	
Consent given?	Yes | No
Consent Provided By:	Patient | LPA for Health | Court Appointed Deputy | Clinician Best Interests Decision (MCA)

Vaccination Details FOR COMPLETION IN THE EVENT OF AN IT OUTAGE			
Dose Round		First	
Time of Vaccination (24hr)	10:40	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			
Vaccine not given (reason)		Unwell | Contraindicated | Did not consent	

Vaccine Record Form

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

Screening Questions (FOR COMPLETION BY PATIENT)	**Yes**	**No**
1. What is your age .....?		
2. If under 65yrs please give reason for vaccination.....		
3. Are you severely immunosuppressed? If so please give reason .....?		
4. Do you have a history of anaphylaxis or significant allergic reaction to any vaccine or its ingredients?		
5. Do you have an egg allergy?		
6. Have you experienced any serious adverse reacion after previous COVID-19 or Influenza vaccinations?		
7. Are you suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for vaccination)?		
8. Are you taking anticoagulant medication, or do you have a bleeding disorder?		
9. Are you or could you be pregnant?		
10. Have you had a COVID vaccine related to Myocarditis or Pericarditis related to a previous Covid vaccination?		

Consent FOR COMPLETION IN THE EVENT OF AN IT OUTAGE	
Consent given?	Yes | No
Consent Provided By:	Patient | LPA for Health | Court Appointed Deputy | Clinician Best Interests Decision (MCA)

Vaccination Details FOR COMPLETION IN THE EVENT OF AN IT OUTAGE			
Dose Round		First	
Time of Vaccination (24hr)	10:50	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			
Vaccine not given (reason)		Unwell | Contraindicated | Did not consent	

Vaccine Record Form

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

Screening Questions (FOR COMPLETION BY PATIENT)	**Yes**	**No**
1. What is your age .....?		
2. If under 65yrs please give reason for vaccination.....		
3. Are you severely immunosuppressed? If so please give reason .....?		
4. Do you have a history of anaphylaxis or significant allergic reaction to any vaccine or its ingredients?		
5. Do you have an egg allergy?		
6. Have you experienced any serious adverse reacion after previous COVID-19 or Influenza vaccinations?		
7. Are you suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for vaccination)?		
8. Are you taking anticoagulant medication, or do you have a bleeding disorder?		
9. Are you or could you be pregnant?		
10. Have you had a COVID vaccine related to Myocarditis or Pericarditis related to a previous Covid vaccination?		

Consent FOR COMPLETION IN THE EVENT OF AN IT OUTAGE	
Consent given?	Yes | No
Consent Provided By:	Patient | LPA for Health | Court Appointed Deputy | Clinician Best Interests Decision (MCA)

Vaccination Details FOR COMPLETION IN THE EVENT OF AN IT OUTAGE			
Dose Round		First	
Time of Vaccination (24hr)	11:00	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			
Vaccine not given (reason)		Unwell | Contraindicated | Did not consent	

Vaccine Record Form

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

Screening Questions (FOR COMPLETION BY PATIENT)	**Yes**	**No**
1. What is your age .....?		
2. If under 65yrs please give reason for vaccination.....		
3. Are you severely immunosuppressed? If so please give reason .....?		
4. Do you have a history of anaphylaxis or significant allergic reaction to any vaccine or its ingredients?		
5. Do you have an egg allergy?		
6. Have you experienced any serious adverse reacion after previous COVID-19 or Influenza vaccinations?		
7. Are you suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for vaccination)?		
8. Are you taking anticoagulant medication, or do you have a bleeding disorder?		
9. Are you or could you be pregnant?		
10. Have you had a COVID vaccine related to Myocarditis or Pericarditis related to a previous Covid vaccination?		

Consent FOR COMPLETION IN THE EVENT OF AN IT OUTAGE	
Consent given?	Yes | No
Consent Provided By:	Patient | LPA for Health | Court Appointed Deputy | Clinician Best Interests Decision (MCA)

Vaccination Details FOR COMPLETION IN THE EVENT OF AN IT OUTAGE			
Dose Round		First	
Time of Vaccination (24hr)	11:10	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			
Vaccine not given (reason)		Unwell | Contraindicated | Did not consent	

Vaccine Record Form

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

Screening Questions (FOR COMPLETION BY PATIENT)	**Yes**	**No**
1. What is your age .....?		
2. If under 65yrs please give reason for vaccination.....		
3. Are you severely immunosuppressed? If so please give reason .....?		
4. Do you have a history of anaphylaxis or significant allergic reaction to any vaccine or its ingredients?		
5. Do you have an egg allergy?		
6. Have you experienced any serious adverse reacion after previous COVID-19 or Influenza vaccinations?		
7. Are you suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for vaccination)?		
8. Are you taking anticoagulant medication, or do you have a bleeding disorder?		
9. Are you or could you be pregnant?		
10. Have you had a COVID vaccine related to Myocarditis or Pericarditis related to a previous Covid vaccination?		

Consent FOR COMPLETION IN THE EVENT OF AN IT OUTAGE	
Consent given?	Yes | No
Consent Provided By:	Patient | LPA for Health | Court Appointed Deputy | Clinician Best Interests Decision (MCA)

Vaccination Details FOR COMPLETION IN THE EVENT OF AN IT OUTAGE			
Dose Round		First	
Time of Vaccination (24hr)	11:20	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			
Vaccine not given (reason)		Unwell | Contraindicated | Did not consent	

Vaccine Record Form

Name	Leona Witt		
DOB	13-Dec-1970		
NHS No.	900679219		
Address	141 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice

Screening Questions (FOR COMPLETION BY PATIENT)	**Yes**	**No**
1. What is your age .....?		
2. If under 65yrs please give reason for vaccination.....		
3. Are you severely immunosuppressed? If so please give reason .....?		
4. Do you have a history of anaphylaxis or significant allergic reaction to any vaccine or its ingredients?		
5. Do you have an egg allergy?		
6. Have you experienced any serious adverse reacion after previous COVID-19 or Influenza vaccinations?		
7. Are you suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for vaccination)?		
8. Are you taking anticoagulant medication, or do you have a bleeding disorder?		
9. Are you or could you be pregnant?		
10. Have you had a COVID vaccine related to Myocarditis or Pericarditis related to a previous Covid vaccination?		

Consent FOR COMPLETION IN THE EVENT OF AN IT OUTAGE	
Consent given?	Yes | No
Consent Provided By:	Patient | LPA for Health | Court Appointed Deputy | Clinician Best Interests Decision (MCA)

Vaccination Details FOR COMPLETION IN THE EVENT OF AN IT OUTAGE			
Dose Round		First	
Time of Vaccination (24hr)	11:30	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			
Vaccine not given (reason)		Unwell | Contraindicated | Did not consent	

Vaccine Record Form

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

Screening Questions (FOR COMPLETION BY PATIENT)	**Yes**	**No**
1. What is your age .....?		
2. If under 65yrs please give reason for vaccination.....		
3. Are you severely immunosuppressed? If so please give reason .....?		
4. Do you have a history of anaphylaxis or significant allergic reaction to any vaccine or its ingredients?		
5. Do you have an egg allergy?		
6. Have you experienced any serious adverse reacion after previous COVID-19 or Influenza vaccinations?		
7. Are you suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for vaccination)?		
8. Are you taking anticoagulant medication, or do you have a bleeding disorder?		
9. Are you or could you be pregnant?		
10. Have you had a COVID vaccine related to Myocarditis or Pericarditis related to a previous Covid vaccination?		

Consent FOR COMPLETION IN THE EVENT OF AN IT OUTAGE	
Consent given?	Yes | No
Consent Provided By:	Patient | LPA for Health | Court Appointed Deputy | Clinician Best Interests Decision (MCA)

Vaccination Details FOR COMPLETION IN THE EVENT OF AN IT OUTAGE			
Dose Round		First	
Time of Vaccination (24hr)	11:40	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			
Vaccine not given (reason)		Unwell | Contraindicated | Did not consent	

Vaccine Record Form

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

Screening Questions (FOR COMPLETION BY PATIENT)	**Yes**	**No**
1. What is your age .....?		
2. If under 65yrs please give reason for vaccination.....		
3. Are you severely immunosuppressed? If so please give reason .....?		
4. Do you have a history of anaphylaxis or significant allergic reaction to any vaccine or its ingredients?		
5. Do you have an egg allergy?		
6. Have you experienced any serious adverse reacion after previous COVID-19 or Influenza vaccinations?		
7. Are you suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for vaccination)?		
8. Are you taking anticoagulant medication, or do you have a bleeding disorder?		
9. Are you or could you be pregnant?		
10. Have you had a COVID vaccine related to Myocarditis or Pericarditis related to a previous Covid vaccination?		

Consent FOR COMPLETION IN THE EVENT OF AN IT OUTAGE	
Consent given?	Yes | No
Consent Provided By:	Patient | LPA for Health | Court Appointed Deputy | Clinician Best Interests Decision (MCA)

Vaccination Details FOR COMPLETION IN THE EVENT OF AN IT OUTAGE			
Dose Round		First	
Time of Vaccination (24hr)	11:50	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			
Vaccine not given (reason)		Unwell | Contraindicated | Did not consent	

Vaccine Record Form

Name	Bartosz Murphy		
DOB	31-Oct-1942		
NHS No.	451757567		
Address	144 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice

Screening Questions (FOR COMPLETION BY PATIENT)	**Yes**	**No**
1. What is your age .....?		
2. If under 65yrs please give reason for vaccination.....		
3. Are you severely immunosuppressed? If so please give reason .....?		
4. Do you have a history of anaphylaxis or significant allergic reaction to any vaccine or its ingredients?		
5. Do you have an egg allergy?		
6. Have you experienced any serious adverse reacion after previous COVID-19 or Influenza vaccinations?		
7. Are you suffering from acute severe febrile illness (the presence of a minor infection is not a contraindication for vaccination)?		
8. Are you taking anticoagulant medication, or do you have a bleeding disorder?		
9. Are you or could you be pregnant?		
10. Have you had a COVID vaccine related to Myocarditis or Pericarditis related to a previous Covid vaccination?		

Consent FOR COMPLETION IN THE EVENT OF AN IT OUTAGE	
Consent given?	Yes | No
Consent Provided By:	Patient | LPA for Health | Court Appointed Deputy | Clinician Best Interests Decision (MCA)

Vaccination Details FOR COMPLETION IN THE EVENT OF AN IT OUTAGE			
Dose Round		First	
Time of Vaccination (24hr)	12:00	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			
Vaccine not given (reason)		Unwell | Contraindicated | Did not consent	