Vaccine Record Form

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 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 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	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) **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 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) **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 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) **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 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 - Check Vaccine Suitability)		
NHS No.	251290912		
Address	126 Test 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 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) **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 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) **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 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) **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 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) **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 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) **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 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) **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 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) **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 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) **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 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) **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 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) **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 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) **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 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) **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 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) **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 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) **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 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) **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 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) **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 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) **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 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) **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 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	