# **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 Questic	ons (FOR COMP	LETION BY PATII	ENT)	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 Healtl	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)		08:30	Date of Vaccination	20/01/20	021
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	

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# **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 Questic	ons (FOR COMP	LETION BY PATII	ENT)	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 Healt	h   Court Appointed Depu	rty   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)		08:30	Date of Vaccination	20/01/20	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 I Contraindicated I Did n	ot consent	

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## Vaccine Record Form

Vaccine not given (reason)

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

Screening Question	Screening Questions (FOR COMPLETION BY PATIENT)				
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 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)		08:40	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 com	nents			
Vaccinator Name					

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# **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

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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					, 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?				severe allergic			
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?				nd/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 Healt	h   Court Appointe	ed Deputy   Cliniciar	Best Interests Decisio	n (MCA)	
Vaccination Do	etails FOR C	COMPLETION IN THE EV	VENT OF AN IT O	UTAGE			
Dose Round				First	First		
Time of Vaccination (24hr) 08:50			Date of Va	Date of Vaccination 20/01/2021			
Vaccine Brand and Batch Number							
Administration Site			Left   Righ	t   Deltoid   Thigh			
Any Adverse Ef	ffects (blank	for none) or other comm	nents				
Vaccinator Name							

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# **Vaccine Record Form**

Vaccine not given (reason)

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 Questic	Screening Questions (FOR COMPLETION BY PATIENT)				
	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 AI	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	VENT OF AN IT OUTAGE	i		
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 comn	nents			
Vaccinator Name					

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# **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 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 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 Provided By:	Patient   LPA for Health	ı   Court Appointed Depu	ıty   Clinician Best Interests Decisi	ion (MCA)	
Vaccination Details FOR C	COMPLETION IN THE EV	ENT OF AN IT OUTAGE			
Dose Round			First		
Time of Vaccination (24hr)		09:10	Date of Vaccination	20/01/20	021
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 not consent		

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# **Vaccine Record Form**

Vaccine not given (reason)

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

Address	120 1631 31	of Flactice Test General Medical Flactice					
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?							
00maant 50D 00	MADI ETIO	NUNTUE EVENT OF AN	LIT OUTAGE				
Consent FOR CO	MPLETIO	N IN THE EVENT OF A	VII OUTAGE				
Consent given?		Yes   No					
Consent Provided	d By:	Patient   LPA for Healtl	n   Court Appointed Dep	outy   Clinician E	Best Interests Decision	n (MCA)	
Vaccination Deta	ails FOR C	OMPLETION IN THE E	/ENT OF AN IT OUTAG	E			
Dose Round				First			
Time of Vaccination (24hr) 09:20			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							

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# **Vaccine Record Form**

Vaccine not given (reason)

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

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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?								
Consent FOR	COMPLETIC	ON IN THE EVENT OF AI	N IT OUTAGE					
Consent given?	?	Yes   No						
Consent Provid	led By:	Patient   LPA for Healt	h   Court Appointed	d Deputy   Clinician E	Best Interests Decision	n (MCA)		
Vaccination De	etails FOR C	COMPLETION IN THE EV	VENT OF AN IT OU	JTAGE				
Dose Round				First				
Time of Vaccination (24hr) 09:30			Date of Vac	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								
Vaccinator Name								

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# **Vaccine Record Form**

Vaccinator Name

Vaccine not given (reason)

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

Address	130 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?						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?						l/or Flu		
Consent FOR	COMPLETIC	ON IN THE EVENT OF AN	NIT OUTAGE					
Consent given	?	Yes   No						
Consent Provid	ded By:	Patient   LPA for Health	n   Court Appoint	ed Deputy   C	Clinician B	est Interests Decisi	on (MCA)	
Vaccination D	etails FOR C	COMPLETION IN THE EV	/ENT OF AN IT C	UTAGE				
Dose Round				Firs	st			
Time of Vaccination (24hr)  Date of				te of Vaco	cination	20/01/20	021	
Vaccine Brand and Batch Number								
Administration Site Left   Ri				ft   Right	Deltoid   Thigh			
Any Adverse Effects (blank for none) or other comments								

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# **Vaccine Record Form**

Vaccine not given (reason)

Name	Loretta Mustafa	国金额国 中 <b>全</b> 数据数		
DOB	30-Aug-1986			
NHS No.	999596593			
Address	131 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice	

Screening Questi	Screening Questions (FOR COMPLETION BY PATIENT)					
If you answer YES discuss with your						
1. Are you feeling u antibiotics?						
2. Do you suffer from reaction?						
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?						
Consent FOR COMPLETION	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	COMPLETION IN THE EV	VENT OF AN IT OUTAGE				
Dose Round			First			
Time of Vaccination (24hr) 09:50			Date of Vaccination	20/01/2	021	
Vaccine Brand and Batch N	Number					
Administration Site		Left   Right   Deltoid   Thigh				
Any Adverse Effects (blank	k for none) or other comr					
Vaccinator Name						

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# **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	

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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?								
Consent FOR	COMPLETIC	ON IN THE EVENT OF AN	I IT OUTAGE					
Consent given?	?	Yes   No						
Consent Provid	led By:	Patient   LPA for Health	ı   Court Appointe	ed Deputy   Clinician	Best Interests Decisio	n (MCA)		
Vaccination Do	etails FOR C	OMPLETION IN THE EV	ENT OF AN IT O	OUTAGE				
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 Left   Right   Deltoid   Thigh				Deltoid   Thigh				
Any Adverse Effects (blank for none) or other comments								
Vaccinator Name								

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# **Vaccine Record Form**

Vaccinator Name

Vaccine not given (reason)

Name	Reeva Smith	©\$∯© N3SSUGA		
DOB	17-Nov-1928			
NHS No.	371062034			
Address	133 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice	

Address	155 1650 5	tieet, bedioid, bb iz SAD		OF Fractice	rest General Medic	cai Fractice		
Screening	Screening Questions (FOR COMPLETION BY PATIENT)						No	
If you answ discuss wi	e, 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 C	OMPLETIO	N IN THE EVENT OF AN	IT OUTAGE					
Consent given?		Yes   No						
Consent Provide	ed By:	Patient   LPA for Health	Court Appointe	ed Deputy   Cliniciar	n Best Interests Decision	on (MCA)		
Vaccination De	tails FOR C	OMPLETION IN THE EVE	ENT OF AN IT O	UTAGE				
Dose Round				First				
Time of Vaccination (24hr)  Date of Vaccin				accination	20/01/20	021		
Vaccine Brand and Batch Number								
Administration Site				Left   Righ	Left   Right   Deltoid   Thigh			
Any Adverse Effects (blank for none) or other comments								

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# **Vaccine Record Form**

Vaccinator Name

Vaccine not given (reason)

Name	Anne Whitmore	回 <b>次</b> 回 25年24		
DOB	25-Nov-1930			
NHS No.	722063876			
Address	134 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice	

Address	154 1650 5	or 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?					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 AN	IT OUTAGE				
Consent given?	?	Yes   No					
Consent Provid	led By:	Patient   LPA for Health	Court Appoint	ed Deputy   Clinician E	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)  10:20			Date of Vac	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							

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## 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?					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 AN	I IT OUTAGE				
Consent given?		Yes   No					
Consent Provid	led By:	Patient   LPA for Health	Court Appoint	ed Deputy   Clinician E	Best Interests Decision	on (MCA)	
Vaccination D	etails FOR (	COMPLETION IN THE EV	ENT OF AN IT O	OUTAGE			
Dose Round				First			
Time of Vaccination (24hr)  10:30  Date of Vaccination				cination	20/01/2	021	
Vaccine Brand and Batch Number							
Administration Site Left   Right   Deltoid   Thigh				Deltoid   Thigh			
Any Adverse Effects (blank for none) or other comments							

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# **Vaccine Record Form**

Vaccinator Name

Vaccine not given (reason)

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

Address	136 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?						ergic		
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 Appoint	ed Deputy   Clir	nician Best Interes	ts Decisior	n (MCA)	
Vaccination D	etails FOR C	COMPLETION IN THE EV	ENT OF AN IT C	UTAGE				
Dose Round First								
Time of Vaccination (24hr) 10:40			Date	of Vaccination		20/01/20	021	
Vaccine Brand and Batch Number								
Administration Site Left   Right   Deltoid   Thigh				high				
Any Adverse Effects (blank for none) or other comments								

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# **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	or Fractice Test Street, Dedicid, DD12 SAD							
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?					llergic			
3. Have you had any severe side effects from previous Covid and/or Flu vaccinations?					I			
Consent FOR (	COMPLETIC	N IN THE EVENT OF AN	IT OUTAGE					
Consent given?	)	Yes   No						
Consent Provid	ed By:	Patient   LPA for Health	Court Appointe	ed Deputy   C	inician Best Intere	ests Decision	ı (MCA)	
Vaccination De	etails FOR C	COMPLETION IN THE EVI	ENT OF AN IT O	UTAGE				
Dose Round				Firs	:			
Time of Vaccination (24hr)  Date of Vaccination					20/01/20	021		
Vaccine Brand and Batch Number								
Administration Site Left   Right   Deltoid   Thigh					Thigh			
Any Adverse Effects (blank for none) or other comments								

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## 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	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 AN	IT OUTAGE				
Consent given		Yes   No					
Consent Provid	ded By:	Patient   LPA for Health	Court Appointe	ed Deputy   Clinici	an Best Interests Dec	ision (MCA)	
Vaccination D	etails FOR C	COMPLETION IN THE EVE	NT OF AN IT O	UTAGE			
Dose Round				First			
Time of Vaccination (24hr)  11:00  Date			Date of	Vaccination	20/01/20	021	
Vaccine Brand and Batch Number							
Administration Site Left   Right   Deltoid   Thigh							
Any Adverse Effects (blank for none) or other comments							

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# 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	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?					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 AN I	T OUTAGE					
Consent given	?	Yes   No						
Consent Provid	ded By:	Patient   LPA for Health	Court Appointe	ed Deputy   Clinician I	Best Interests Decision	on (MCA)		
Vaccination D	etails FOR C	COMPLETION IN THE EVE	NT OF AN IT O	UTAGE				
Dose Round First								
Time of Vaccination (24hr)  11:10  Date			Date of Vac	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								

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# **Vaccine Record Form**

Vaccinator Name

Vaccine not given (reason)

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

Addiess	140 1631 3	treet, beardra, bb12 3Ab		OF FIA	Clice	rest General Medic	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						please		
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 (	COMPLETIO	N IN THE EVENT OF AN	IT OUTAGE					
Consent given?	•	Yes   No						
Consent Provid	led By:	Patient   LPA for Health	Court Appointe	ed Deputy	y   Clinician E	Best Interests Decision	on (MCA)	
Vaccination De	etails FOR C	OMPLETION IN THE EVE	NT OF AN IT O	OUTAGE				
Dose Round First								
Time of Vaccination (24hr) 11:20				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								

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## Vaccine Record Form

Vaccinator Name

Vaccine not given (reason)

Name	Leona Witt		回為第回 (1967年8月	
DOB	13-Dec-1970	(X33,53X) ■ (12.7)		
NHS No.	900679219			
Address	141 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice	

Address	mileet, bedioid, bb12 3Ab	OF	Fractice	rest General Medic	ai Fractice		
Screening Questions (FOR COMPLETION BY PATIENT)						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 COMPLETION	ON IN THE EVENT OF AN	IT OUTAGE					
Consent given?	Yes   No						
Consent Provided By:	Patient   LPA for Health	Court Appointed De	puty   Clinician	Best Interests Decisio	n (MCA)		
Vaccination Details FOR	COMPLETION IN THE EVE	ENT OF AN IT OUTA	GE				
Dose Round			First				
Time of Vaccination (24hr)  11:30  Date of Vaccination			ecination	20/01/20	021		
Vaccine Brand and Batch Number							
Administration Site			Left   Right	Left   Right   Deltoid   Thigh			
Any Adverse Effects (blank	( for none) or other comme	ents					

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## Vaccine Record Form

Vaccinator Name

Vaccine not given (reason)

Name	Karina Rowland		国 (2.6) 国 (3.6) (2.4)	
DOB	29-Aug-1948			
NHS No.	349888464			
Address	142 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice	

Address	142 Test S	treet, Bedford, BD12 3AD		GP Pra	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?					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									

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# **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, bealord, 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						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?						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								

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# **Vaccine Record Form**

Vaccine not given (reason)

Name	Bartosz Murphy		回%》回 33(4) (63	
DOB	31-Oct-1942	17646655 ■ (3786)		
NHS No.	451757567			
Address	144 Test Street, Bedford, BD12 3AD	GP Practice	Test General Medical Practice	

Address 144	Test Street, Dealord, DD12 SAD	or Fractice Test General Medical Fractice					
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?							
0	N ETION IN THE EVENT OF AN	IT OUT A OF					
Consent FOR COMP	PLETION IN THE EVENT OF AN	II OUTAGE					
Consent given?	Yes   No						
Consent Provided By	r: Patient   LPA for Health	Court Appointed Depu	uty   Clinician E	Best Interests Decision	n (MCA)		
Vaccination Details	FOR COMPLETION IN THE EV	ENT OF AN IT OUTAGE	:				
Dose Round			First				
Time of Vaccination (24hr) 12:00			Date of Vaccination 20/01/2021			021	
Vaccine Brand and B	atch Number						
Administration Site			Left   Right   Deltoid   Thigh				
Any Adverse Effects	(blank for none) or other comm	ents					
Vaccinator Name							

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