

## Record a vaccination form

### Date of vaccination

DD MM YYYY	
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### Site (only if your organisation has more than 1 site for vaccinations)

Site name	
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### Vaccinator's name

First and last name	
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### Vaccine details

Vaccination type (for example, flu)	
Product name (for example, Fluenz)	
Batch number	
Batch expiry date DD MM YYYY	

### Why are you giving the patient the vaccine?

Eligibility reason	
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### If the patient is a healthcare worker, what is their role?

(only for flu if the patient is eligible because they are a healthcare worker)

Staff role	<input type="checkbox"/> Doctor <input type="checkbox"/> Qualified nurse or midwife <input type="checkbox"/> All other professionally qualified clinical staff <input type="checkbox"/> Clinical support <input type="checkbox"/> Non-clinical
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### If the patient is pregnant, what is their due date? (only for pertussis and RSV)

DD MM YYYY	
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### Where is the vaccination taking place? (only for COVID-19)

<input type="checkbox"/> On site <input type="checkbox"/> Care home <input type="checkbox"/> Housebound patient's home <input type="checkbox"/> Outreach event
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If the location is a care home, enter the name or ODS code of the care home

Name or ODS code	
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**Patient details**

NHS number	
First name	
Last name	
Date of birth DD MM YYYY	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown
Postcode	

**Consent**

Consent given by	<input type="checkbox"/> Patient <input type="checkbox"/> Clinician acting in the patient's best interests <input type="checkbox"/> Person with lasting power of attorney for health and welfare <input type="checkbox"/> Parent or guardian <input type="checkbox"/> Independent mental capacity advocate <input type="checkbox"/> Court appointed deputy
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If someone gave consent on behalf of the patient, enter their details

Name	
Relationship to patient	

**Where did you give the injection? (only for injected vaccines)**

<input type="checkbox"/> Left arm <input type="checkbox"/> Right arm <input type="checkbox"/> Left buttock <input type="checkbox"/> Right buttock <input type="checkbox"/> Left thigh <input type="checkbox"/> Right thigh
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**Did you give a full dose of the vaccine? (only for Fluenz nasal flu vaccine)**

<input type="checkbox"/> Yes, both nostrils <input type="checkbox"/> No, 1 nostril only
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