Pre-immunisation Questionnaire Medical Records are stored electronically ad are subject to Data Protection Acts 1988 & 1993	
Surname:	
Forename:	
Date of Birth:	
Contact Tel No:	
Time out Post Vaccine:	

1.	Have you had Anaphylaxis (serious allergic reaction requiring medical intervention) following a previous dose of the vaccine or any of its constituents? Inc polyethylene glycol [PEG] If yes you are not eligible for the vaccination at this time. See patient information leaflet.	Yes ☐ No ☐
2.	Have you been diagnosed with Covid-19 within the last four weeks? If yes, you will not be eligible for vaccination until four weeks after your COVID-19 diagnosis.	Yes ☐ No ☐
3.	Have you had another vaccine within the last 14 days? If yes you will not be eligible until 14 days after your last vaccination.	Yes ☐ No ☐
4.	Do you have a bleeding disorder or are you on anticoagulation therapy?	Yes ☐ No ☐
5.	Are you less than 14 weeks or more than 33 weeks pregnant? If yes, you are not eligible for vaccination at this time. If no, but you are more than 14 weeks and less than 33 weeks pregnant and consenting to vaccination, before vaccination happens please discuss the risks and benefits of receiving the vaccine with your obstetric care provider and confirm with them that you are at the correct stage of pregnancy to receive the vaccine	Yes ☐ No ☐
		☐ ☐

COVID-19Vaccine 1st Dose	**Signed patient**	**Date:**
2nd Dose	**Signed patient**	**Date:**

Vaccine Name 1st Dose	**Expiry Date:**	**Vaccine Label:**	**Batch Number**
Administered By:			

Vaccine Name 2nd Dose	**Expiry Date:**	**Vaccine Label:**	**Batch Number**
Administered By:			