Community Pharmacy Influenza Immunisation Consent & Record Form

Surname:	Forenames(s):
Date of Birth:	Telephone Number/contact details:
Home Address:	GP/Medical Practice: Address:

Please answer the following questions and mark either 'Yes' or 'No' giving details where required

Medical Details	**Yes/No**	**Dates and Details**
Do you take tablets/medicine for any reason?		
Are you allergic to anything - food (e.g. eggs), drugs, animals etc?		
Do you suffer from asthma or hay fever?		
Do you suffer from a long term or recurring illness?		
Are you or do you think you may be pregnant?		
Are you breast-feeding at present?		
Have you had any severe reactions to previous vaccines e.g. rash, tongue swelling, shortness of breath?		
Have you had any other immunisations or vaccinations during the last six weeks?		
Are you well today?		

I have read the Influenza Information Leaflet and had the procedure and its implications explained to me. The above information is correct and I consent to having Influenza Vaccine from a trained pharmacist. I confirm that I have not been previously vaccinated with influenza vaccine for this coming winter and understand that the pharmacist will inform my GP of my influenza vaccination.

Patient/Adult with parental responsibility/Carer Signature: ____________________**Date:** ____________

For the Pharmacist to complete:

I have explained the procedure and administered the following 0.5mL influenza vaccine administered by IM injection into the deltoid muscle in the LEFT / RIGHT arm (delete as appropriate). If another site has been used please document below:

Alternative site____

Date administered:		**Pharmacy stamp**
Product	Affix product sticker	
Manufacturer:		
Expiry & Batch Number		
Adverse reactions noted: *(if applicable)*		
Pharmacist Signature:		**GPhC number**
Print Name		

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