|  |
| --- |
|  Full name: |
| Date of birth: |
| Home address: | Telephone number: |
| Patients ethnicity: |

|  |  |  |
| --- | --- | --- |
| Have you had a positive COVID-19 test in the last 28 days? | YES | NO |
| Are you under 16? | YES | NO |
| Do you currently have a severe illness with high temperature or a cough? | YES | NO |
| Did you experience a severe allergic reaction to your previous COVID-19 vaccinations? | YES | NO |
| IF you are on warfarin treatment – was your last INR blood test in range? | YES | NO |
| Are you taking any medicines that effect blood clotting or blood thinning? Ex. Apixaban, Rivaroxaban, Dabigatran or Edoxaban | YES | NO |
| Are you pregnant, think you might be pregnant or are you planning to get pregnant within the next three months? | YES | NO |
| Are you breastfeeding? | YES | NO |
| Have you had any other vaccine or injection in the last 7 days? If so what? | YES | NO |
| Are you taking part in any clinical trials involving medicines or vaccines?  | YES | NO |
| Do you consent to receive the 3rd dose of COVID 19 vaccine (Pfizer) | YES | NO |

**To be completed by clinician-**

|  |  |  |
| --- | --- | --- |
| Does the patient consent to vaccination? | YES | NO |
| Does the patient agree to be monitored for 15 minutes following vaccination if there is a small risk of significant adverse reactions to the vaccine? | YES | NO |

|  |  |  |
| --- | --- | --- |
| Vaccination site (circle) | Left arm | Right Arm |
| Time of vaccination |  |
| Vaccinating clinician | Name (Print): | Signature: |