NHS Flu Jab Private Flu Jab

# Flu Vaccination Consent Form

* indicates sections that must be completed

| 1.Patient's details | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| First name* | | | | | | | | | Surname* | |
| Address | | | | | | | | | | |
| Postcode | | | | | | | | | Telephone | |
| Date of birth* | D | D | M | M | Y | Y | Y | Y | NHS No. | |
| GP practice | | | | | | | | | | |

| 2.Patients Health | | |
|---|---|---|
| Any history of anaphylaxis | Yes | No |
| Current Medication? | | |
| Any medical conditions? | | |
| Have you had a reaction to a previous vaccine | Yes | No |
| Have you had a flu vaccine before? | Yes | No |
| Have you had a severe allergic reaction to eggs and / or antibiotics or a previous vaccine? | Yes | No |
| Are you currently suffering from an acute viral infection? | Yes | No |
| Are you immunocompromised? | Yes | No |
| Are you pregnant, possibly pregnant or breastfeeding? | Yes | No |

**3.Patient consent**

1. I agree to be given a flu vaccination by a trained pharmacist.
2. I confirm I have not already received a flu vaccination for this flu season.
3. I declare that the information I have given on this form is correct and complete.
4. I consent to the disclosure of relevant information, where appropriate, from this form to:
   - my GP practice to help them provide care to me; and
   - NHS England (the national NHS body that manages pharmacy and other health services) and the NHS BSA for the purposes of checking payments to the pharmacy and to allow them to make sure the service is being provided properly.

| Signature | | Date | | | |
|---|---|---|---|---|---|

| To be completed by pharmacy staff | | |
|---|---|---|
| NHS Eligibility for Free NHS Flu vaccination - patient group* | ☐ 65 years or over | ☐ Chronic respiratory disease |
| | ☐ Chronic heart disease | ☐ Chronic kidney disease |
| | ☐ Chronic liver disease | ☐ Chronic neurological disease |
| | ☐ Diabetes | ☐ Immunosuppression |
| | ☐ Asplenia / splenic dysfunction | ☐ Pregnant woman |
| | ☐ Person in long-stay residential care home or care facility | ☐ Carer |
| | ☐ Household contact of immunocompromised individual | ☐ Morbid obesity (BMI ≥ 40) |

| Vaccination details | | | | | | | |
|---|---|---|---|---|---|---|---|
| Vaccine/ manufacturer | Apply vaccine sticker if available | Date of vaccination* | | | | | |
| Batch Number | | Injection site* | | | | Route of administration* | |
| Expiry Date | | ☐ Left upper arm<br>☐ Right upper arm | | | | ☐ Intramuscular<br>☐ Subcutaneous | |
| Any adverse effects* | | | | | | | |
| Advice given and any other notes | | | | | | | |

| Administered by* (pharmacist name) | | Signature * | | GPhC number * | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|