

Assessment, consent and PSD form for use with COVID-19 mRNA vaccine BNT162b2 (Pfizer/BioNTech) at the PCN Designated Site

Vaccine recipient details

First Name		Date of birth	
Surname			
Home address			
		Postcode	
Phone/Mobile		Email address	

Please read and answer the following questions carefully. Information provided will be used to assess your suitability to receive the Covid-19 vaccine. If you answer yes to any questions, you may be asked for further information to assess your suitability to receive the Covid-19 vaccine.

Are you under 16 years of age?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Do you currently have a severe illness with a high temperature?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
*Have you ever had a severe reaction to a medicine, vaccine or to food or carry an adrenaline autoinjector (such as EpiPen® or Jext®)?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
If this is your second dose of the Covid-19 vaccine, did you experience any significant side effects after the first dose	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Are you pregnant, think you might be pregnant or planning to get pregnant in the next three months? Refer to ' COVID-19 vaccination: a guide for women of childbearing age, pregnant, planning a pregnancy or breastfeeding ' for information.	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Are you breastfeeding?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Have you had confirmed Covid-19 infection in the last 4 weeks?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Have you had the flu vaccine in the last 7 days?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Have you had a dose of the Covid-19 vaccine in the last 21 days?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
If this is your second dose of the Covid-19 vaccine, did you have an adverse reaction to the first dose?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Are you taking part in any clinical trials involving medicines or vaccines?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Are you taking any medicines that affect blood clotting or for blood thinning? Examples of these medicines include aspirin, clopidogrel, apixaban, rivaroxaban, dabigatran or edoxaban.	No <input type="checkbox"/>	Yes <input type="checkbox"/>
If you take warfarin, are you awaiting an INR result or was your latest INR result higher than your target range?	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Do you have bleeding problems or a bleeding disorder?	No <input type="checkbox"/>	Yes <input type="checkbox"/>

FOR COMPLETION BY VACCINATOR ONLY - Consent to vaccination

Has the vaccine recipient read the written information provided?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the person being assessed happy to receive the Covid-19 vaccine following assessment by a vaccinator?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the vaccine recipient agree to be monitored for at least 15 minutes following vaccination as there is a small risk of significant adverse reactions to the vaccine?	Yes <input type="checkbox"/>	No <input type="checkbox"/>