Care Home Resident		Housebound		Other	

Lichfield PCN Covid 19 Vaccination Site: Greenhill Health Centre

Practice Name:
THE WESTGATE PRACTICE

Name		**Surname**	
Date of Birth		**NHS Number**	**(if known)**
Home Address Including Postcode			

The person presenting for vaccination must answer both questions below and confirm that they have received appropriate counselling as to the purpose of the vaccine, side effects and that they wish to proceed to vaccination.

	Pre-vaccination screening	**Please circle**	**Helpful notes**
1.	Do you have a history of anaphylaxis or significant allergic reactions to any vaccines or its ingredients?	Y / N	
2.	Have you experienced any serious adverse reaction after previous COVID-19 vaccine doses?	Y / N	

To be completed by Clinician/Administrator

Batch No	**Expiry date**	**Use by date**	**Vaccine administered by**	**Vaccine constituter**	**Date and time**	**Site of injection**