## Immunisation Assessment Form (for non-travel related vaccinations)



Please only fill in the page 1.

**Vaccine(s) requested:** **Date: ……../……/……**

| **Title, Name AND Address** (details of the person receiving the vaccine)**:** | **Date of Birth: ……../……/…….**<br><br>**Male** □ **Female** □ |
|---|---|
| **Mobile or Landline:**<br><br>**Email:** | **GP Surgery's Name & Address:**<br><br>GP Fax No (if known):<br>Would you like your GP to be notified of this consultation? **Yes** □ **No** □ |

**Please supply details of your personal medical history**

| | YES | NO | DETAILS |
|---|---|---|---|
| Are you (*person receiving the vaccine*) fit and well today | | | |
| **Any Allergies** including food (esp. **egg**), latex, medication | | | |
| **Have you had any vaccinations in the past 4 weeks** | | | |
| **Severe reaction to a vaccine before** | | | |
| Tendency to faint with injections | | | |
| Any surgery in the past, esp. if to do with **spleen or thymus** | | | |
| **Recent (last 12 months) chemotherapy/radiotherapy/organ transplant / immunosuppressive drugs/ steroids** | | | |
| Anaemia | | | |
| **Bleeding /clotting disorders** (including history of DVT) | | | |
| Heart disease | | | |
| Diabetes | | | |
| Epilepsy/seizures | | | |
| Gastrointestinal (stomach) complaints | | | |
| Liver and or kidney problems | | | |
| **HIV**/AIDS | | | |
| **Immune system condition** | | | |
| Mental health issues (including anxiety, depression) | | | |
| Neurological (nervous system) illness | | | |
| Respiratory (lung) disease | | | |
| Rheumatology (joint) conditions | | | |
| Spleen or Thymus problems | | | |
| **Any other conditions?** | | | |
| **Women Only** | | | |
| Are you **pregnant**? | | | |
| Are you breast feeding? | | | |

**Are you currently taking any medication** (including prescribed, purchased or a contraceptive pill)?
If yes, please list name and doses:

## Immunisation Management Form



To be filled in by the health professional.

**Vaccine(s) requested:** Date:

| **Patient name:** | **DOB:** |
|---|---|
| | ……/……/…….. |
| **Advice provided** | **Tick & note details as appropriate** |
| Benefits and potential side effects of vaccine(s) discussed | |
| Patient Information Leaflet (PIL) given | |
| Post vaccination advice given | |

**Consent**

I have received information on the risks and benefits of the medicines recommended and fully understand them. I have also had the opportunity to ask questions. I consent to the recommended vaccine (s) being given at each appointment to complete the relevant course (s).

**Patient signature (parent / guardian Name & Signature if applicable) & Date:**

## Vaccination(s) prescribed and administered

Following the completion of an immunisation consultation and consent given above, the below named medicines prescribed and administered.

| **Name, Batch No & Expiry Date** | **Dose, Schedule, Route & Site(s) used** | **Date vaccine given** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| **Name and Signature of Prescriber** | | **Date** |
| **Mahyar Saremi, Pharmacist Independent Prescriber, GPhC no: 2069409** | | |
| **Name and Signature of Vaccinator** (if different from the prescriber) | | **Date** |
| | | |

| **Post Vaccination administration** | |
|---|---|
| Prescription written by the prescriber & details recorded on patient computer record | **Y / N** |
| Fees paid: Per Dose or In Full | **Y / N** |
| GP notified (if consent given) | **Y / N** |