Walthamstow Pharmacy Influenza Vaccination Record & Consent Form

* indicates sections that must be completed

Patient's details					
First name*					
Surname*					
Address					
Postcode					
Telephone					
Date of birth*		NHS Number			
GP practice*					

Patient's emergency contact	
Name	
Telephone	
Relationship to patient	

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) 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

Any allergies		
Eligible patient group*	☐ Aged over 65	☐ Chronic respiratory disease
	☐ Chronic heart disease	☐ Chronic kidney disease
	☐ Chronic liver disease	☐ Chronic neurological disease
	☐ Diabetes	☐ Immunosuppression
	☐ Splenic dysfunction	☐ Pregnant woman
	☐ Person in long-stay residential or home	☐ Carer
	☐ Household contact of immunocompromised individual	

Vaccination details

Name of vaccine/ manufacturer*	Apply vaccine sticker if available	Date of vaccination*				Pharmacy stamp
Batch Number*		Injection site*	☐ Left upper arm ☐ Right upper arm			
Expiry Date*		Route of administration*	☐ Intramuscular ☐ Subcutaneous			
Any adverse effects*						
Advice given and any other notes						
Administered by* (pharmacist name)		Signature*		GPhC number*		