pharmadoctor

Influenza vaccine
Risk Assessment Form

Title: Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other ☐	**D.o.B.:** _ _ / _ _ / _ _	**Age:** _____
Home postcode:	**Home Address:**	
Name:		
Surname:	**Name & Address of GP** (optional)	
Email:		
Telephone:	**Would you like your GP to be informed of this consultation?** Yes ☐ No ☐	

Please answer the following questions (must be completed by parent or guardian if under 16)

Do you feel unwell, have a temperature or an infection?	Yes ☐ No ☐	Women only: Are you currently breast-feeding?	Yes ☐ No ☐
Have you ever had an allergic or anaphylactic reaction to an influenza vaccine or any other vaccine before? *If yes, please describe the reaction*	Yes ☐ No ☐	Do you have any allergies (e.g. egg, latex, antibiotics)? *If yes, please describe the allergy/reaction*	Yes ☐ No ☐
Women only: Are you pregnant, or is there any possibility that you could be pregnant?	Yes ☐ No ☐	Do you feel any stress related reactions (e.g. feeling faint) when receiving a vaccine?	Yes ☐ No ☐
Are you immunosuppressed due to disease or treatment (e.g., HIV)? *If yes, please provide details*	Yes ☐ No ☐	Do you have any recent or past medical history of note? *If yes, please provide details*	Yes ☐ No ☐
Do you have a bleeding disorder, including taking any medication that thins your blood (anticoagulants)?	Yes ☐ No ☐	Are you aware that some people in high risk groups may be entitled to have the Flu vaccine free on the NHS? *Your pharmacist will discuss this with you if you are eligible*	Yes ☐ No ☐
Do you have an unstable or evolving neurological condition?	Yes ☐ No ☐	Have you already had a flu vaccine for this flu season?	Yes ☐ No ☐
Are you likely to come into close contact with severely immunocompromised patients?	Yes ☐ No ☐	Do you have severe asthma, difficulty breathing, or are you receiving salicylate therapy?	Yes ☐ No ☐

Please list all your current prescription medication including any medication you buy over the counter

PATIENT CONSENT

I have received information on the risks and benefits of the vaccine and I have had the opportunity to ask questions. The medical information I have provided is true and accurate to the best of my knowledge and I consent to the vaccine being given. I understand that details of this consultation will be uploaded to an online platform for electronic storage and will ask a member of staff if I have any questions about how my personal data is processed.

Signature of patient, parent or guardian _____ **Date** _____

HEALTHCARE PROFESSIONAL USE ONLY

Vaccine brand, batch number and expiry date	*Affix vaccine label here or write details*	Site of injection	Route of administration	Date	Cost
		L deltoid ☐ R deltoid ☐ Anterolateral thigh ☐	Intramuscular ☐ Subcutaneous ☐ Nasal (Fluenz Tetra) ☐		

I confirm that the patient is not contraindicated based on the information provided by the PGD	☐
I have explained the potential warnings and side effects of the vaccine to the patient, and requested they report them if they occur	☐
I have provided the patient with an information leaflet (PIL) for the vaccine I am administering, and advised them to read it	☐

Healthcare Professional Name	**Signature**