|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Staff Details** | | | | | | | | | |
| Name of Staff Member | |  | | | | | | | |
| Date of Birth: | |  | | | | | | | |
| NHS Number | |  | | | | | | | |
| **Employers Details** | | | | | **GP Details (patients only)** | | | | |
| Name & Location | | | | | GP Name | | | | |
| Telephone | | | | | GP Telephone | | | | |
| Name & Job Title of Person Administrating Vaccine | | | | | GP Address | | | | |
| **Inclusion Criteria** | | | | | | | | | |
| **Please tick which category makes you eligible for vaccination from the list below;**    Member of Staff | | | | | | | | | |
| **Suitability** | | | | **Please circle** | | | **If yes, give details** | | |
| 1. Are you currently suffering from an acute illness/fever | | | | Yes | | No |  | | |
| 2. Have you had a seasonal flu vaccine before | | | | Yes | | No |  | | |
| 3. Do you have an allergy to eggs/chicken protein | | | | Yes | | No |  | | |
| 4. Do you have a latex allergy | | | | Yes | | No |  | | |
| 5. Have you had a severe reaction to seasonal flu vaccine or any other vaccine before | | | | Yes | | No |  | | |
| 6. Do you have a blood disorder i.e. haemophilia | | | | Yes | | No |  | | |
| 7. Have you received any vaccine in the last 4 weeks | | | | Yes | | No |  | | |
| **CONSENT**  **I the above named member of staff give consent to be vaccinated. I confirm that I am eligible to receive the vaccination as a Frontline Health Care Worker. I agree to inform and share these details with my registered GP practice.**  Signature……………………………………………………………. Date …………………… | | | | | | | | | |
| **Immunisation Details** | | | | | | | | | |
| **Vaccine name** | **Product name** | | **Batch number** | **Expiry date** | | | | **Dose** | **Site** |
|  |  | |  |  | | | |  |  |
| Name of vaccinator………………………….….. Signature…………..…………………… Date………………. | | | | | | | | | |
| **Employers Action - Please ensure that this vaccination is reported on ImmForm under** **Seasonal Flu survey for Frontline** **Health Care workers (HCW’s). Please note: Employers are not eligible to claim for the administration of this vaccination.** | | | | | | | | | |

**Staff Influenza Immunisation Record**