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| --- |
| **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**