# Staff Influenza Immunisation Record

| **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.**