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.