**COVID Vaccination Service Clinical Screening Form**

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| Patient Name: |  |
| Date of Birth: |  |
| NHS Number: |  |
| 1. Is the individual currently unwell with a fever, or having any symptoms of COVID-19 infection?  | Yes / No |
| 2. Is the individual aged 18 or over, and had any COVID-19 symptoms or tested positive for COVID-19 over the last 4 weeks?  | Yes / No |
| 3. Has the individual been vaccinated against shingles in the last 7 days?”  | Yes / No |
| 4. Does the individual have a history of any of the following? - Anaphylaxis - Reaction to a previous dose of COVID-19 vaccine - Significant unexplained allergies  | Yes / No |
| 5. Has the individual informed you they are currently or have been in a trial of a potential coronavirus vaccine?  | Yes / No |
| 6. Has the individual been previously diagnosed with COVID-19 vaccine-related myocarditis or pericarditis?  | Yes / No |
| 7. Does the individual have a history of capillary leak syndrome?  | Yes / No |
| 8. Does the individual have a history of Idiopathic Thrombocytopenia (ITP)?  | Yes / No |
| 9. Is the individual taking anticoagulant medication, or do they have a bleeding disorder?  | Yes / No |
| 10. The VidPrevtyn Beta vaccine contains squalene, an ingredient derived from a fish oil. Do you have any religious, ethical or medical reasons why you cannot have this vaccine? | Yes / No |
| Name of Clinician: |  |
| Date of Vaccination: |  |
| Signature: |  |