



# Vaccination record (for vaccinator use)

Consumer details confirmed  Affirmative answer to any screening questions?  Yes  No

If yes, record the detail and advice given \_\_\_\_\_

Verbal and written post vaccination information given

Previous vaccination records checked prior to administration and other eligible vaccines offered eg Tdap / MMR / Shingles

Discussed with consumer influenza vaccines available and pros and cons of these as appropriate

Informed consent obtained?  Yes  No

<b>Influvac Tetra (Funded)</b> 6 months and over	Dose 1 <input type="checkbox"/> 6 months and over	Dose 2* <input type="checkbox"/> 6 months – 3 years
<b>Flucelvax (Unfunded)</b> 6 months and over	Dose 1 <input type="checkbox"/> 6 months and over	Dose 2* <input type="checkbox"/> 6 months – 3 years
<b>Fluzone (Unfunded)</b> 6 months and over	Dose 1 <input type="checkbox"/> 6 months and over	Dose 2* <input type="checkbox"/> 6 months – 3 years
<b>Fluad (Unfunded)</b> 50 years and over	Dose 1 <input type="checkbox"/> 65 years and over	

\*Two doses separated by at least four weeks if a flu vaccine is being administered for the first time.

Flu vaccination details							
Name of vaccine	Batch	Expiry	Dose	Needle size	Site	Date	Time
Write vaccine name or place vaccine sticker here					Deltoid <input type="checkbox"/> L <input type="checkbox"/> R		
<input type="checkbox"/> Funded <input type="checkbox"/> Non-funded							
Other vaccines given (vaccinator must ensure informed consent has been obtained for these)							
Vaccine details	Batch	Expiry	Dose	Needle size	Site	Date	Time
Write vaccine name or place vaccine sticker here					Deltoid <input type="checkbox"/> L <input type="checkbox"/> R		

<p><b>Vaccinator information</b></p> <p>Place of vaccination _____</p> <p>_____</p> <p>Name _____</p> <p>Signature _____</p>	<p><b>Observation period</b></p> <p><input type="checkbox"/> Details of any AEFI or observations recorded</p> <p><input type="checkbox"/> CARM report completed</p> <p>Signature _____</p> <p>Departure time _____</p>
<p><b>Clinical supervisor (if relevant)</b></p> <p>Name _____</p> <p>Signature _____</p>	