pharmadoctor

Varicella (chickenpox) vaccine
Risk Assessment Form

Title: Mr: ☐ Miss: ☐ Ms: ☐ Mrs: ☐ Other: ☐	**D.o.B.:** _ _ / _ _ / _ _	**Age:** ________

Name:	**Home Address:**
Surname:	
Email:	**Name & Address of GP** (optional)
Telephone:	Would you like your GP to be informed of this consultation? Yes ☐ No ☐

Please answer the following questions (must be completed by parent or guardian if under 16)

Have you ever had an allergic or anaphylactic reaction to a chicken pox vaccine or any other vaccine before? *If yes, please describe the reaction*	Yes ☐ No ☐	Women only: Are you pregnant, planning pregnancy, or is there any possibility that you could be pregnant? *Pregnancy should be avoided for at least 1 month following vaccination*	Yes ☐ No ☐
Do you feel unwell, have a temperature or an infection?	Yes ☐ No ☐	Women only: Are you breast-feeding?	Yes ☐ No ☐
Do you have any allergies? (e.g. gelatin) *If yes, please describe the allergy/reaction*	Yes ☐ No ☐	Do you have a hereditary and degenerative disease of the nervous system or muscles; or a severe neurological disability or learning disability?	Yes ☐ No ☐
Have you ever had an allergic or anaphylactic reaction to antibiotics (e.g. neomycin, streptomycin, polymyxin B)?	Yes ☐ No ☐	Do you have untreated tuberculosis, or are you due to have a skin test for possible tuberculosis?	Yes ☐ No ☐
Are you immunosuppressed due to disease or treatment (e.g., HIV)? *If yes, please provide details*	Yes ☐ No ☐	Do you have a blood disorder or any type of malignant cancers including leukaemia and lymphomas that affects the immune system?	Yes ☐ No ☐
Does anyone in your family/family history have an immune disorder? *If yes, please provide details*	Yes ☐ No ☐	Are you aware that you should avoid the use of salicylates (e.g. aspirin) for 6 weeks after receiving the vaccine?	Yes ☐ No ☐
Do you have a bleeding disorder, including taking any medication that thins your blood (anticoagulants)?	Yes ☐ No ☐	Do you have an existing skin condition that has damaged your skin?	Yes ☐ No ☐
Do you feel any stress related reactions (e.g. feeling faint) when receiving a vaccine? *If yes, please provide details*	Yes ☐ No ☐	Are you in close contact with any high risk individuals? High risk individuals include: - People with a weakened immune system - Pregnant women who have never had chickenpox (varicella) - New-born babies whose mothers have never had chickenpox (varicella)	Yes ☐ No ☐
Have you had chicken pox before?	Yes ☐ No ☐	Have you been in contact with anyone that has chicken pox in the last 3 days?	Yes ☐ No ☐
Are you aware that you should avoid contact with any high-risk individuals for 6 weeks after receiving the vaccine?	Yes ☐ No ☐	Have you received any blood or plasma transfusions, or been administered human immune globulin or varicella zoster immune globulin in the last 5 months?	Yes ☐ No ☐
Have you been told by your doctor you have an intolerance to any sugars? *If yes, please provide details*	Yes ☐ No ☐	Are you aware that vaccination does not completely protect all individuals from naturally acquired varicella?	Yes ☐ No ☐

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Please answer the following questions (must be completed by parent or guardian if under 16)
Please list all your current prescription medication including any medication you buy over the counter
Please provide details of any recent or past medical history of note (e.g. other conditions that you have previously been treated for)
Please list all vaccines that you have received in the last 4 weeks, and provide dates if known

Shingles	☐	Date:	Yellow Fever	☐	Date:	Oral typhoid	☐	Date:
Chicken Pox	☐	Date:	Influenza	☐	Date:	MMR	☐	Date:
Others (please name)	☐							

PATIENT CONSENT

I have received information on the risks and benefits of the vaccine and I have had the opportunity to ask questions. The medical information I have provided is true and accurate to the best of my knowledge and I consent to the vaccine being given.

Signature of patient, parent or guardian ___________________________________ **Date** ______________________________________

HEALTHCARE PROFESSIONAL USE ONLY	
Non-supply/administration	
I confirm that the patient did NOT receive the medication ☐	**Patient referred to GP** ☐
Reason for non-supply/administration	

HEALTHCARE PROFESSIONAL USE ONLY					
Supply/administration					
Vaccine brand, batch number and expiry date	*Affix vaccine label here or write details*	L deltoid ☐ R deltoid ☐ Anterolateral thigh ☐	Intramuscular ☐ Deep SC ☐	Date	Cost
I confirm that the patient is not contraindicated based on the information provided by the PGD					☐
I have explained the potential warnings and side effects of the treatment to the patient, and requested they report them if they occur					☐
I have provided the patient with an information leaflet (PIL) for the treatment I am administering, and advised them to read it					☐
Healthcare Professional Name			**Signature**		