PGD Risk Assessment Form
Flu/Covid Vaccination

Name of patient			Address
Date of birth	Age	M / F	
Contact number			
GP surgery			Postcode

Please answer the following questions accurately		
	Y/N	*Comments*
Do you have any allergies? (Egg, latex or other)		
Have you ever had a severe allergic reaction, or a reaction to a vaccination in the past?		
Do you feel unwell or have a temperature today?		
Do you have kidney or liver problems?		
Are you pregnant or breast feeding?		
Do you have a low immune system or take medication that can affect your immune system? (e.g. steroids, treatment for cancer)		
Medical history/current medications		

Consent
I have answered the questions above accurately, and received information about my treatment. I consent to treatment being given. Signed Date
Informed consent, from the individual or a person legally able to act on the person's behalf, must be obtained for each consultation. If you are signing on behalf of another person / child, please add your details below: Name Address

Produced by ECG Professional Support
Emergency Care Gateway LTD.

For professional use only		
Details of Flu/Covid Vaccination supplied under PGD *(Name of medication, strength, dose, quantity)*		Batch No Expiry
Site of injection	*Route of administration* *SC / IM*	
I can confirm the following: • Treatment has been supplied in accordance with the PGD • The PIL has been supplied and advice given if side effects occur • Was the patient referred to a clinician / GP (if 'YES' give details below) • Reason if treatment was not supplied (give details below)		
Advice given, including advice given if the patient is excluded or declines immunisation		
Details of any adverse drug reactions and actions taken		
Additional information / notes		
Name of practitioner	Signature	Date