**Clinician Name:**

|  |  |
| --- | --- |
| **Time of vaccination:**  | **Vaccination setting:****Harbourside (Vacc site)**  |

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| **Consent given by** (please circle)**:**Patient / Healthcare LPA / Court appointed deputy / Clinician (in best interests) |
| **Patient name** |  | **Date of birth** |  |
|  | **Postcode** |  |
| **Practice****(Please Circle)** | Harbourside Family PracticePortishead Medical GroupClevedon Medical CentreHeywood Surgery (Pill)  | **Gender** | Male / Female / Not specified |
| **Injection site:** **Left / Right Deltoid** | **Dose given:** **1st / 2nd** | **Adverse reaction?** **Y / N** |

**Your ethnicity (please circle):**

1. White – British
2. White – Irish
3. White – Other
4. Mixed – White and Black Caribbean
5. Mixed – White and Black African
6. Mixed – White and Asian
7. Mixed – Other mixed groups
8. Indian
9. Pakistani
10. Bangladeshi
11. Other Asian background
12. Caribbean
13. African
14. Other black background
15. Chinese
16. Any other ethnic group
17. Not stated