PGD Risk Assessment Form
Flu or Covid Vaccination – Private Service

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

Please answer the following questions accurately	
Do you have any allergies? (Egg, latex or other)	Do you have any heart problems, or previous heart surgery?
Have you ever had a severe allergic reaction, or a reaction to a vaccination in the past?	Do you have kidney or liver problems?
Do you feel unwell or have a temperature today?	Do you have epilepsy?
Do you have a low immune system or take medication that can affect your immune system? (e.g. steroids, treatment for cancer)	Do you have a neurological condition?
Are you pregnant or breast feeding?	Do you have diabetes?
Do you have asthma or lung problems?	Do you have problems with depression, anxiety or other mental health problems?
If you have answered 'YES' to any of the questions above, please give details:	
Medical history:	

Current medications prescribed by a doctor, or bought over the counter from a pharmacy:

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

For professional use only		
Details of vaccination supplied under PGD *(Name/brand of vaccine, strength, dose, quantity)*		Batch No Expiry
For SC / IM injections only: *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)		
Additional information / notes		
Cost of treatment to patient	Paid Y / N	
Name of registered healthcare practitioner	Signature	Date