FLU BOOKING FORM

Allcare Pharmacy

NAME: _____

CONTACT NUMBER: _____

ADDRESS: _____

PPS:_____ GMS: _____

DOB: _____ GUARDIAN NAME:_____

(6 months – 12 years, please refer to a Pharmacist)

GP: _____

DATE & TIME OF BOOKING: _____

MEDICAL HISTORY:

Have you had the flu vaccine before?

_____

Do you or a family member have a condition that affects the immune system?

_____

Have you ever had an allergic reaction to any previous vaccinations?

_____

Are you allergic to eggs or chicken?

_____

COVID QUESTIONS:

Do you have symptoms of cough, fever, high temperature, sore throat, breathlessness, or flu like symptoms now or in the past 14 days? *If answered Yes to this please outline symptoms

_____

Have you been diagnosed with or suspected as having COVID-19 infection in the last 14 days?

_____

Have you recently returned to Ireland from a 'high risk' COVID area?

_____

Are you a close contact of a person who is a confirmed or a suspected case of COVID-19 in the past 14 days?

_____

ADVICE TO CUSTOMER:

- Please advise customer that they will get their temperature checked on the day and will need to wear a mask.
- Wear loose fitting clothes on top as it is an intramuscular injection into the top of arm
- There is a 15-minute wait after the vaccination to ensure no adverse effects.