Pre-screening COVID-19 Vaccination Dose 1

Date:	
Name of resident to be vaccinated:	
Date of birth:	
Temperature:	
Pulse:	
SaO2:	
Please indicate if there is an informed consent for the person to be vaccinated: ☐ Yes ☐ No	

The following screening questions are to be completed for each resident who is to be vaccinated on the day of vaccination. A tick is to be placed in each box and the completed screening form is to be shown to the immunisation provider immediately prior to vaccination.

- ☐ is unwell today
- ☐ has a disease that lowers immunity (e.g., leukaemia, cancer, HIV) or is having treatment that lowers immunity (e.g., oral steroid medicines such as cortisone and prednisone, DMARDs [disease-modifying anti-rheumatic drugs], radiotherapy, chemotherapy)
- ☐ has had a severe reaction following any vaccine
- ☐ has ***any*** severe allergies (to anything)
- ☐ has had any vaccine in the past month
- ☐ has a history of Guillain–Barré syndrome
- ☐ has a severe or chronic illness please list

  _____

  _____

  _____
- ☐ has a bleeding disorder or is on anti-coagulation therapy
- ☐ is awaiting results of COVID 19 test
- ☐ has a positive COVID 19 test result

Name: _____ **Signature:** _____

Date: _____

Pre-screening COVID-19 Vaccination Dose 2

Date:	
Name of resident to be vaccinated:	
Date of birth:	
Temperature:	
Pulse:	
SaO2:	
Please indicate if there is an informed consent for the person to be vaccinated: ☐ Yes ☐ No	

The following screening questions are to be completed for each resident who is to be vaccinated on the day of vaccination. A tick is to be placed in each box and the completed screening form is to be shown to the immunisation provider immediately prior to vaccination.

- ☐ is unwell today
- ☐ has a disease that lowers immunity (e.g., leukaemia, cancer, HIV) or is having treatment that lowers immunity (e.g., oral steroid medicines such as cortisone and prednisone, DMARDs [disease-modifying anti-rheumatic drugs], radiotherapy, chemotherapy)
- ☐ has had a severe reaction following any vaccine
- ☐ has ***any*** severe allergies (to anything)
- ☐ has had any vaccine in the past month
- ☐ has a history of Guillain–Barré syndrome
- ☐ has a severe or chronic illness please list
  _____
  _____
  _____
- ☐ has a bleeding disorder or is on anti-coagulation therapy
- ☐ is awaiting results of COVID 19 test
- ☐ has a positive COVID 19 test result

Name: _____ **Signature:** _____

Date: _____

Post COVID-19 Vaccination Screening Dose 1

Date of Vaccination:	
Time:	
Name of Resident:	

Date	Time	Pain at Site	Temp.	SaO2	Headache	Chills	Initials

Post COVID-19 Vaccination Screening Dose 1

Date of Vaccination:	
Time:	
Name of Resident:	

Date	Time	Pain at Site	Temp.	SaO2	Headache	Chills	Initials