Community Pharmacy COVID-19 Vaccination Service (CPVS)
Comirnaty JN.1 COVID Vaccination Record Form

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Comirnaty JN.1 (30 micrograms/dose) dispersion for injection
COVID-19 mRNA Vaccine (nucleoside modified)

Note: Payment cannot be claimed via this paper form. All payments are made following VMS submission.

Section 1.	**Patient details**		
First Name:		**Surname:**	
Registered GP Practice:		**Date of Birth:**	
Health and Care Number:		**Gender at birth:**	**Male** ☐ **Female** ☐
Address / Care Home Address:			
Town/City:		**Postcode:**	
Mobile Number:		**Email Address:**	

Section 2.	**Cohort**
Eligible Cohort (Autumn 2024 programme)	**Aged 65 years or over** ☐ **Frontline HSCW** ☐ **Clinical risk group** ☐ **Immunocompromised** ☐ **Care home resident** ☐ **Care home Staff** ☐ **RQIA care home number** ☐ (Individuals must be 18yrs and above)

Vaccine Safety Check	Is the patient currently unwell with a high temperature or fever?	Yes ☐ No ☐
	Has the patient had COVID-19 in the last 14 days and not fully recovered from it?	Yes ☐ No ☐
	Has the patient had a serious allergic reaction to any medicine?	Yes ☐ No ☐
	Has the patient had a serious allergic reaction to any vaccine?	Yes ☐ No ☐
	Does the patient have a bleeding disorder or is taking anticoagulant medication (e.g. warfarin, apixaban)?	Yes ☐ No ☐
	Is the patient on any immunosuppressive medication or due to start any immunosuppressive medication?	Yes ☐ No ☐
	Has the patient been previously diagnosed with COVID-19 vaccine-related myocarditis or pericarditis?	Yes ☐ No ☐

Proceed to Vaccinate:	Yes ☐ No ☐	If no, state reason:	
Patient consents and is content pharmacist confirms declaration on their behalf. (TICK TO CONFIRM)			Yes ☐

Section 4.	**BOOSTER DOSE Bivalent Vaccination Details**		
Booster Dose:	**0.3ml [zero.three millilitres]**	**Date of vaccination:**	
Name of Vaccine:	**Comirnaty JN.1 (30 micrograms/dose) dispersion for injection COVID-19 mRNA Vaccine**	**Route of Administration:**	**IM** ☐
Batch number:		**Thawed Expiry Date:**	
Injection Site (tick applicable):	**Left Upper Arm** ☐ **Right upper Arm** ☐		
Any Adverse Effects:		**Advice given:**	
Administered by (Vaccinator Name):		**Signature:**	