

Community Pharmacy COVID-19 Vaccination Service (CPVS)  
Comirnaty KP.2 COVID Vaccination Record Form

Comirnaty KP.2 (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:		Sex at birth:	Male <input type="checkbox"/> Female <input type="checkbox"/>
Address / Care Home Address:			
Town/City:		Postcode:	
Mobile Number:		Email Address:	
Section 2. Cohort			
Eligible Cohort (Autumn 2025 Programme)	Criteria		Tick
	Aged 75 years and over		<input type="checkbox"/>
	Resident of a care home	RQIA Code:	<input type="checkbox"/>
	Immunosuppressed person		<input type="checkbox"/>
Vaccine Safety Check	Is the patient currently unwell with a high temperature or fever?		Yes <input type="checkbox"/> No <input type="checkbox"/>
	Has the patient had a serious allergic reaction to any medicine?		Yes <input type="checkbox"/> No <input type="checkbox"/>
	Has the patient had a serious allergic reaction to any vaccine?		Yes <input type="checkbox"/> No <input type="checkbox"/>
	Does the patient have a bleeding disorder or is taking anticoagulant medication (e.g. warfarin, apixaban)?		Yes <input type="checkbox"/> No <input type="checkbox"/>
	Is the patient on any immunosuppressive medication or due to start any immunosuppressive medication?		Yes <input type="checkbox"/> No <input type="checkbox"/>
	Has the patient been previously diagnosed with COVID-19 vaccine-related myocarditis or pericarditis?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Patient consents and is content pharmacist confirms declaration on their behalf. (TICK TO CONFIRM)			Yes <input type="checkbox"/>
Proceed to Vaccinate:	Yes <input type="checkbox"/> No <input type="checkbox"/>	If no, state reason:	
Section 4. BOOSTER DOSE Bivalent Vaccination Details			
Booster Dose:	<b>0.3ml [zero.three millilitres]</b>	Date of vaccination:	
Name of Vaccine:	Comirnaty KP.2 (30 micrograms/dose) COVID-19 mRNA Vaccine	Route of Administration:	IM <input type="checkbox"/>
Batch number:		Thawed Expiry Date:	
Injection Site (tick applicable):	Left Upper Arm <input type="checkbox"/> Right upper Arm <input type="checkbox"/> Other injection site <input type="checkbox"/> _____		
Any Adverse Effects:		Advice given:	
Administered by (Vaccinator Name):		Signature:	