Care home name and address			Pharmacy name:
RQIA care home number[s]			Contractor number:
Care home lead:			Pharmacist / clinical supervisor:
Summary:	Potential number of residents to be vaccinated _____	The number of residents for whom a best interest decision will require to be made: _____	

The following patients will give consent to vaccination or will require a best interest decision.

FOR CARE HOME USE							FOR PHARMACY USE Care Home RQIA code: _____ Date of vaccinations: _____		
	Patient Name	**Date of Birth**	**Health & Care number**	**Vaccine to be Administered**	**Consent or best interest decision C or BI**	History of significant allergy **YES / NO**	Pharmacist / clinical supervisor **Signature**	Influenza Vaccine **[Flu]** Administered	**COVID-19** Vaccine Administered
e.g.	*A. N. Other*	*01/4/53*	*0123456789*	**Flu** ✔ **COVID** ✔	*C*	*BI*	*NO*	*Pharmacist*	✔	✔
1				**Flu** ❑ **COVID** ❑					❑	❑
2				**Flu** ❑ **COVID** ❑					❑	❑
3				**Flu** ❑ **COVID** ❑					❑	❑
4				**Flu** ❑ **COVID** ❑					❑	❑
5				**Flu** ❑ **COVID** ❑					❑	❑
6				**Flu** ❑ **COVID** ❑					❑	❑

Note: assessment of best interests

When assessing best interests the vaccinator must confirm that to the best of their knowledge, the person named has not refused this procedure in a valid advance directive. Where possible and appropriate, they have consulted with colleagues and those close to him/her; and believe the procedure to be in his/her interests.

COVID-19 / Seasonal Influenza VACCINATION OF CARE HOME RESIDENTS

Updated 11/08/2026

FOR CARE HOME USE							FOR PHARMACY USE Care Home RQIA code: _____ Date of vaccinations: _____		
	Patient Name	**Date of Birth**	**Health & Care number**	**Vaccine to be Administered**	**Consent or best interest decision C or BI**	History of significant allergy **YES / NO**	Pharmacist / clinical supervisor **Signature**	Influenza Vaccine **[Flu]** Administered	**COVID-19** Vaccine Administered
7				**Flu** ❑ **COVID** ❑				❑	❑
8				**Flu** ❑ **COVID** ❑				❑	❑
9				**Flu** ❑ **COVID** ❑				❑	❑
10				**Flu** ❑ **COVID** ❑				❑	❑
11				**Flu** ❑ **COVID** ❑				❑	❑
12				**Flu** ❑ **COVID** ❑				❑	❑
13				**Flu** ❑ **COVID** ❑				❑	❑
14				**Flu** ❑ **COVID** ❑				❑	❑
15				**Flu** ❑ **COVID** ❑				❑	❑
16				**Flu** ❑ **COVID** ❑				❑	❑
17				**Flu** ❑ **COVID** ❑				❑	❑
18				**Flu** ❑ **COVID** ❑				❑	❑
19				**Flu** ❑ **COVID** ❑				❑	❑
20				**Flu** ❑ **COVID** ❑				❑	❑

Note: assessment of best interests

When assessing best interests the vaccinator must confirm that to the best of their knowledge, the person named has not refused this procedure in a valid advance directive. Where possible and appropriate, they have consulted with colleagues and those close to him/her; and believe the procedure to be in his/her interests.

COVID-19 / Seasonal Influenza VACCINATION OF CARE HOME RESIDENTS

Updated 11/08/2026

FOR CARE HOME USE							FOR PHARMACY USE Care Home RQIA code: _____ Date of vaccinations: _____		
	Patient Name	**Date of Birth**	**Health & Care number**	**Vaccine to be Administered**	**Consent or best interest decision C or BI**	History of significant allergy **YES / NO**	Pharmacist / clinical supervisor **Signature**	Influenza Vaccine **[Flu]** Administered	**COVID-19** Vaccine Administered
21				**Flu** ❑ **COVID** ❑				❑	❑
22				**Flu** ❑ **COVID** ❑				❑	❑
23				**Flu** ❑ **COVID** ❑				❑	❑
24				**Flu** ❑ **COVID** ❑				❑	❑
25				**Flu** ❑ **COVID** ❑				❑	❑
26				**Flu** ❑ **COVID** ❑				❑	❑
27				**Flu** ❑ **COVID** ❑				❑	❑
28				**Flu** ❑ **COVID** ❑				❑	❑
29				**Flu** ❑ **COVID** ❑				❑	❑
30				**Flu** ❑ **COVID** ❑				❑	❑
31				**Flu** ❑ **COVID** ❑				❑	❑
32				**Flu** ❑ **COVID** ❑				❑	❑

Note: assessment of best interests

When assessing best interests the vaccinator must confirm that to the best of their knowledge, the person named has not refused this procedure in a valid advance directive. Where possible and appropriate, they have consulted with colleagues and those close to him/her; and believe the procedure to be in his/her interests.