

Vaccination Record

Reference Number

CLIENT DETAILS

PPSN

Card No.

Patient's Name

Address

Date of Birth

Gender

Increased Medical Risk Code

TO BE COMPLETED IN WRITING BY PATIENT

1. I verify that I have received an injection of Influenza Vaccination.
2. I confirm that I consented to have myself / the above named person vaccinated with Influenza Vaccination.
3. **Data Protection Notice:** Personal data collected by HSE PCRS is used for the purpose of providing a health service. It is required, stored, processed and disclosed to other bodies in accordance with the laws relating to proper treatment of personal data.

Signature (Mandatory)

PRACTITIONER DETAILS

Contractor No.

Contractor's Name

Address

SIGNATURE AND STAMP OF CONTRACTOR: The vaccination detailed hereon has been given by me.

If different from above, enter name (in Block Capitals) of the person who provided the vaccination.

Professional Reg. No.:

Cold Chain Acc. No.:

VACCINATION DETAILS

Vaccination Date

Batch Number

Name of Vaccine

Manufacturer

Injection Site

Expiry Date

Vacc. Type

Shot 1

Batch Number

Name of Vaccine

Manufacturer

Injection Site

Expiry Date

Vacc. Type

Shot 2

INCREASED MEDICAL RISK CODES

- a) Chronic Respiratory Disease (including asthma and cystic fibrosis)
- b) Pregnant woman
- c) Chronic Heart Disease
- d) Chronic Renal Disease
- e) Chronic Liver Disease
- f) Chronic Neurological Disease
- g) Immunosuppressed
- h) Household Contacts (of immunosuppressed)
- i) Diabetes Mellitus
- j) Morbidly Obese
- k) Haemoglobinopathies