COVID-19 VACCINATION BOOKING FORM

MANSFIELD DISTRICT HOSPITAL

CLIENT DETAILS:			Date: / /
Medicare Number:			Ref No:
First Name:			
Middle Name:			
Surname:			ID Check ☐
Gender:	☐ Male	☐ Female	☐ Unspecified
Phone Number:			
Email address:			
Address:	Street/Unit Number:		
	Street:		
	City:	State:	P/Code:
Date of birth:	DD/MM/YYYY / /		
Indigenous Status:	☐ Neither indigenous Australian or Torres Strait Islander ☐ Aboriginal ☐ Both Aboriginal and Torres Strait Islander ☐ Not declared		
Country of Birth:			
Preferred Language:			
MEDICAL ALERTS:			
Which medical practice do you go to	☐ CGP	☐ MMC	☐ Other

CLINICAL USE ONLY

VACCINATION EPISODE		
Client / Vaccinee Name:	Name:	DOB: / /
STATUS:	DATE: / / 2021	
	CHECK IN TIME: : AM/PM	
PROVIDER:		
Questionnaire & Consent completed:	☐ Pre-vaccination questionnaire ☐ Consent	

VACCINE DETAILS	
Vaccine Name:	
Vaccine Batch:	
Expiry Date:	/ / 2021
Manufacture Date:	/ / 2021
Dosage:	
Dilutent:	
Vaccination Route:	

ADMINISTRATION		
Dose	☐ Dose 1	☐ Dose 2
Administration Site:	☐ Deltoid LEFT	☐ Deltoid RIGHT
	☐ Other	
Date administered:	/ / 2021	
Time administered:	: AM/PM	
ADVERSE EVENT :	☐ No	☐ Yes – refer to Adverse event form
Vaccinated By:	Name:	
	Designation:	
	Signed:	

MONITORING	☐ 15 Minutes	Start time:
	☐ 30 minutes	End time: AM/PM
CHECK OUT TIME	Time: :	AM/PM