Community Pharmacy – Record Form

Name:	
Date of Birth	
Address:	
Postcode:	
GP Practice:	

Please select place of work:

GCC – Adult services	
GCC – Children services	
GCC – Corporate Resources	
GCC – EE&I	
GCC – Community Safety (Inc GFRS)	
Gloucester City Council	
GCC Local Authority/voluntary aided school (include Name of School below): **Please note: Academy Schools are not eligible via GCC flu campaign** Name of School:	
Gloucestershire County Council elected members	
Gloucester City elected members	

Emergency Contact Details:

Name	
Telephone	
Relationship	

Patient Declaration:

1. I understand I am being given a flu vaccination by a trained pharmacist.
2. I confirm I have not already received a flu vaccination for this flu season.
3. I declare that the information I have given on this form is correct and complete.
4. I understand relevant information, where appropriate, from this form will be disclosed to my GP practice to help them provide care to me.
5. I understand that the information on this form will be used in line with the Pharmacies privacy notice.

I understand that to provide this service to me free of charge that Gloucestershire County Council requires the following performance management information. I understand that if I am not willing to provide the following information that I will be ineligible to receive the service. I understand that my personal data will be managed by Gloucestershire County Council in accordance with the relevant Privacy Notice available at https://www.gloucestershire.gov.uk/council-and-democracy/data-protection/service-specific-privacy-notices/corporate-services-privacy-notice/

Signed:	Date:

CONFIDENTIAL GCC2025FLU

Please complete this form and take it to your flu vaccination appointment for completion by the Pharmacist

To be completed by pharmacy staff

Any allergies	

Eligible patient group:

Pregnant woman		Chronic respiratory disease	
Diabetes		Chronic kidney disease	
Aged 65 and over		Chronic neurological disease	
Carer		Chronic heart and vascular disease	
Household contact of immunocompromised individual		Chronic liver disease	
Splenic dysfunction/Asplenia		Immunosuppression	
Person in long-stay residential or home		Chronic neurological disease	

Vaccination details:

Name of Vaccine/ Manufacturer*	Apply vaccine sticker if available	Date of Vaccination*		
		Time of Vaccination*		
		Injection Site*	Left upper arm	
Batch Number*			Right upper arm	
Expiry Date*		Route of Administration*	Intramuscular	
			Subcutaneous	

Any adverse effects	
Advice given/additional notes	
Administered by (Pharmacist name)	
GPhC Number	
Signature	

CONFIDENTIAL GCC2025FLU

Please complete this form and take it to your flu vaccination appointment for completion by the Pharmacist