

COVID-19 CLIENT DETAIL – APPOINTMENT BOOKING FORM

First Name _____ Middle Name _____ Last Name _____

Gender (indicate): Female Male Other

If Female Please Indicate: Pregnant Not pregnant

Date of Birth: ____/____/____ Age: ____



You will need to bring age identification with you to pharmacy at the time of your appointment.

Indicate which
vaccination cohort
(if unsure please ask
a member of the
pharmacy team)

Residents and staff of long term care facilities
Front line Health Care Workers
People with a VERY HIGH risk medical condition
People with a HIGH risk underlying condition

Key workers essential to the vaccination programme
People living or working in crowded settings
Allocation group based on age

Mothers Birth Surname: _____

Nationality: _____

Ethnicity: Irish Any other black background Other (including mixed background)
Irish Traveller Chinese Prefer not to say
Any other white background Any other Asian background
African Roma

PPS Number: _____ No PPS Number

Reason No PPS Number: _____

Email address: _____

Mobile: _____ Alternate Contact No: _____

Address Details:

Eircode (if available): _____

GP Details

GP Name: _____

GP Practice Name: _____

GP Address: _____

GP Eircode: _____

Not Registered with a GP

GP Phone Number: _____