



COVID-19 Vaccination

MUST BE 12+

Revised 09/2025

Please fill out the requested information completely:

- 1) Name: _____ Birthdate: _____
- 2) Which arm would you like to use? LEFT RIGHT
- 3) I am 65 years of age or older No Yes
- 4) I am between the ages of 12 and 64 years with at least one underlying condition that puts me at high risk for severe outcomes from COVID-19. No Yes
- 5) Last COVID-19 vaccination date? _____ (must be at least 2 months since previous dose)
- 6) Are you feeling sick today? No Yes, describe _____
- 7) Have you had an allergic reaction after a previous COVID-19 vaccine or to a component of the COVID-19 vaccine? No Yes, describe _____
- 8) Have you had a severe allergic reaction to another vaccine (other than COVID-19 vaccine) or another injectable medication? No Yes, describe _____
- 9) Do you have a history of myocarditis or pericarditis? No Yes
- 10) Do you have a history of multisystem inflammatory syndrome (MIS-C or MIS-A)? No Yes
- 11) Have you had COVID-19 in the last 3 months? No Yes

Signature of Person to Receive Vaccine (or Signature of Parent/Guardian if Patient is < 18 years old):

Patient Signature (if 14+): _____ Date: _____

Parent/Guardian Signature(under 18 only): _____ Date: _____

We will add a record of this vaccination to the Wisconsin Immunization Registry (WIR) to keep your records with your other health care providers up-to-date. You may decline to be added to WIR; it will then be your responsibility to notify your health care providers as needed. If you do NOT want this vaccination added to the WIR, check this box: Do NOT submit a record of this vaccination to the Wisconsin Immunization Registry

Please provide your insurance card(s) with this form if you want the vaccine billed to insurance.