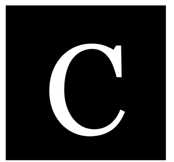

COVID-19 Vaccination
(2024-2025 Pfizer Formula)
MUST BE 12+
Form for: Moderate to Severe IMMUNOCOMPROMISED

Please fill out the requested information completely:

1) Name: ____ Birthdate: ____________________

2) Which arm would you like to use? ☐ LEFT ☐ RIGHT

3) Are you feeling sick today? ☐ No ☐ Yes, describe ________________________________

4) How many TOTAL COVID vaccines have you received in the past?

   ☐ None

   ☐ 1 Circle: Moderna Pfizer Novavax Janssen Unknown

   ☐ 2 Circle: Moderna Pfizer Novavax Janssen Unknown

   ☐ 3 or more (Do not need to know vaccine manufacturer if 3 or more vaccines have been received.)

5) Date of most recent COVID vaccine ____________________

   Circle: Moderna Pfizer Novavax Janssen Unknown

6) Have you had an allergic reaction after a previous COVID-19 vaccine or to a component of the COVID-19 vaccine? ☐ No ☐ Yes, describe ____

7) Have you had a severe allergic reaction to another vaccine (other than COVID-19 vaccine) or another injectable medication? ☐ No ☐ Yes, describe ____

8) Do you have a history of myocarditis or pericarditis? ☐ No ☐ Yes

9) Do you have a history of multisystem inflammatory syndrome (MIS-C or MIS-A)? ☐ No ☐ Yes

10) To be considered moderately to severely immunocompromised, one or more of the following conditions must exist. Read carefully and check ALL that apply:

   ☐ Receiving active cancer treatment for tumors or cancers of the blood

   ☐ Received an organ transplant and are taking medicine to suppress the immune system

Question #10 (continued)

□ Received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system

□ Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)

□ Advanced or untreated HIV infection

□ Active treatment with high-dose corticosteroids (i.e., ≥20mg prednisone or equivalent per day for > 14 days) or other drugs that may suppress your immune response [e.g., alkylating agents (cyclophosphamide); antimetabolites (methotrexate); transplant-related immunosuppressive drugs (cyclosporine, tacrolimus, everolimus); TNF-blockers (etanercept)]

□ Other condition(s) which cause moderate or severe immunosuppression similar to the above conditions. Please describe ____________________________________

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.