CHET JOHNSON DRUG
Amery, Wisconsin

C

COVID-19 Vaccination

(2024-2025 Pfizer Formula)

MUST BE 12+

NOT Immunocompromised

Please fill out the requested information completely:

1) Name: _____ Birthdate: _____
2) Last COVID-19 vaccination date? _____ (must be 8 weeks since previous dose)
3) Which arm would you like to use? ☐ LEFT ☐ RIGHT
4) Are you feeling sick today? ☐ No ☐ Yes, describe _____
5) Have you had an allergic reaction after a previous COVID-19 vaccine or to a component of the COVID-19 vaccine? ☐ No ☐ Yes, describe _____
6) Have you had a severe allergic reaction to another vaccine (other than COVID-19 vaccine) or another injectable medication? ☐ No ☐ Yes, describe _____
7) Do you have a history of myocarditis or pericarditis? ☐ No ☐ Yes
8) Do you have a history of multisystem inflammatory syndrome (MIS-C or MIS-A)? ☐ No ☐ Yes
9) 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.