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CHET JOHNSON DRUG
Amery, Wisconsin

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# Shingles (Shingrix)

## Vaccination

Please fill out the requested information completely:

1) Name: _____ Birthdate: _____

2) Weight:

| MALE: | FEMALE: |
|---|---|
| ☐ Less than 130lbs | ☐ Less than 130lbs |
| ☐ Between 130lbs and 260lbs | ☐ Between 130lbs and 200lbs |
| ☐ More than 260lbs | ☐ More than 200lbs |

3) Allergies:

☐ No allergies

☐ Other vaccines or vaccine components: _____

☐ Other allergies: _____

4) Have you received any other vaccinations in the last month:

☐ No ☐ Yes (please list): _____

5) Are you currently experiencing any acute illness such as a cold, fever or other infection?

☐ No ☐ Yes (Please describe): _____

6) In the past 3 months, have you taken any immunosuppressant medications (e.g. prednisone, cyclosporine, etc.) or are you immune suppressed due to a medical condition (e.g. HIV, leukemia, cancer, etc)?

☐ No ☐ Yes (describe, list drug and dose):_____

7) 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.

☐ Do NOT submit a record of this vaccination to the Wisconsin Immunization Registry

8) Please sign and date:

Signature: _____ Date: _____

*If you would like us to bill insurance for this vaccination, please provide your insurance card(s) with this form.*