CHET JOHNSON DRUG
Amery, Wisconsin

S

Shingles (Shingrix)

Vaccination

Please fill out the requested information completely:

1) Name: _____ Birthdate: _____

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

3) Allergies:

   ☐ No allergies

   ☐ Other vaccines or vaccine components: _____

   ☐ Other allergies: _____

4) Are you currently experiencing symptoms of active shingles:

   ☐ No ☐ Yes

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

   ☐ No ☐ Yes (Please describe): _____

6) 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

7) Please sign and date:

Signature: _____ Date: _____

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