CHET JOHNSON DRUG
Amery, Wisconsin

P

Pneumonia (pneumococcal)

Vaccination
AGES 19+

Please fill out the requested information completely:

1) Name: _____ Birthdate: _____
2) Age Category: ☐ Age 50+ ☐ Age 19-49
3) Which arm would you like to use? ☐ LEFT ☐ RIGHT
4) Allergies:
   - ☐ No allergies
   - ☐ PCV or any diptheria-toxoid-containing vaccine
   - ☐ Other vaccines or vaccine components: _____
   - ☐ Other allergies: _____
5) Have you ever received a pneumonia vaccine:
   ☐ No ☐ Yes (date): _____ ☐ Unknown
6) Do you live in a nursing home or other long-term care facility[1]? ☐ Yes ☐ No

   [1]Retirement communities and independent living communities for seniors are not considered long-term care facilities

7) Do you have any of the following conditions that increase the risk of pneumonia?
   (Please read carefully and check ALL that apply.)

- □ chronic renal failure
- □ nephrotic syndrome
- □ immunodeficiency
- □ latrogenic immunosuppression
- □ generalized malignancy
- □ HIV
- □ Hodgkin disease
- □ Leukemia
- □ Lymphoma
- □ multiple myeloma
- □ solid organ transplant
- □ congenital or acquired asplenia
- □ sickle cell disease
- □ other hemoglobinopathies (Please explain) _____
- □ Cochlear implant
- □ Cerebrospinal fluid leak

8) Do you have any of the following chronic medical conditions?

- □ alcoholism
- □ cigarette smoking
- □ diabetes
- □ Chronic heart disease, includes congestive heart failure (CHF) and cardiomyopathies, excludes hypertension
- □ Chronic lung disease, includes chronic obstructive pulmonary disease (COPD), emphysema, and asthma
- □ Chronic renal failure or liver disease

9) Are you pregnant? □ No □ Yes

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

□ No □ Yes (Please describe): _____

11) 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

12) Please sign and date:

Signature: _____ Date: _____

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