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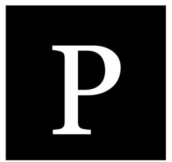

Pneumococcal

Vaccination

Please fill out the requested information completely:

1) Name: ____ Birthdate: ____________________

2) Weight: MALE:
   - ☐ Less than 130lbs
   - ☐ Between 130lbs and 260lbs
   - ☐ More than 260lbs

   FEMALE:
   - ☐ Less than 130lbs
   - ☐ Between 130lbs and 200lbs
   - ☐ 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 or other infection?

   ☐ No ☐ Yes (Please describe): ____

6) Are you currently taking any immunosuppressant medications (e.g. prednisone, cyclosporine, etc) or are you immune suppressed due to a medical condition (e.g. HIV, leukemia, etc)?

   ☐ No ☐ Yes (for drugs, 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 Medicare or insurance for this vaccination, please provide your insurance card(s) with this form.