Iverson Corner Drug
408 Minnesota Ave
Bemidji, MN 56601

Iverson Corner Drug Pneumococcal Vaccination Screening Questionnaire and Informed Consent Form

Name:_____ Date of Birth:_____

Address:_____ City:_____

Phone #:_____ Zip: _____

Allergies:_____

Screening Questionnaire for Adult Immunization

	Yes	No
1. Are you sick today?	□	□
2. Do you have allergies to medication, foods, or vaccines, (especially eggs, latex, or thiomersal)?. . . (If so, please list)_____	□	□
3. Do you have a weakened immune system caused by something like HIV, cancer, immunosuppressive therapy or any other immune system problem?	□	□
4. Have you ever had a serious reaction or Guillian-Barre Syndrome after receiving a vaccine	□	□
5. Have you been vaccinated with a pneumococcal vaccine in the past? (Prevnar 13, PneuumoVax 23, Vacneuvance, etc).	□	□
6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had X-ray treatments (for cancer)?.	□	□
7. During the past year, have you received a transfusion of blood or blood products, or been given immune(gamma) globulin?	□	□
8. For women: Are you pregnant or is there a chance you could become pregnant in the next 3 months?	□	□
9. If you are UNDER 65, do you have any of the following risk factors (ignore if OVER 65) .	□	□

- □ Smoking or chronic alcohol use
- □ Chronic Heart Disease, CHF or cardiomyopathies
- □ COPD, emphysema, or asthma
- □ Diabetes mellitus
- □ Cerebrospinal fluid leak
- □ Chronic liver disease
- □ Cochlear implant

I, the undersigned, wish to receive a vaccination against pneumonia. I am taking this vaccine voluntarily and consent to the vaccination being given to me. I have read the information provided (pneumonia VIS). I understand the risks and benefits of this vaccine. I have had an opportunity to ask questions which have been answered to my satisfaction. I hereby waive any claim for damages that I (or anyone claiming on my behalf) may have against Iverson Corner Drug, its pharmacists, nurses, directors, or employees on account of any injury or misfortune I may suffer as a result of this vaccination.

Patient Signature:_____ Date:_____

For Office Use Only

Manuf.	Lot #	Exp. Date	Site:	Date of Admin/Date Given VIS:	Signature of Admin/Title	Date on VIS
						05/12/2023