Iverson Corner Drug
408 Minnesota Ave
Bemidji, MN 56601

Iverson Corner Drug RSV Vaccination Screening Questionnaire and Informed Consent Form

Name:_____ Date of Birth:_____

Address:_____ City:_____

Phone #:_____ Zip: _____

Allergies:_____

Screening Questionnaire for Adult RSV Immunization

	Yes	No
1. Are you over the age of 60?	□	□
2. Are you sick today?	□	□
3. Do you have allergies to medication, foods, or vaccines, (especially sucrose)?	□	□
a. If so, please list _____		
4. Have you ever had a serious reaction or Guillain-Barre Syndrome after receiving a vaccine?	□	□
5. Do you have a weakened immune system caused by something such as HIV, cancer, or immunosuppressive therapy?	□	□
6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had X-rays?	□	□
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 under the age of 75, do you have any of these chronic medical conditions or risk factors?	□	□

- □ Lung diseases (including COPD and asthma)
- □ Diabetes mellitus
- □ Neurologic or neuromuscular conditions
- □ Kidney disorders
- □ Liver disorders
- □ Bleeding disorders
- □ Cardiovascular disease (including CHF and CAD)
- □ Moderate or severely immunocompromised (either attributable to a medical condition or receipt of immunosuppressive medication or treatment)

I, the undersigned, wish to receive a vaccination against respiratory syncytial virus. I am taking this vaccine voluntarily and consent to the vaccination being given to me. I have read the information provided (respiratory syncytial virus 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
						10/17/24