Iverson Corner Drug
408 Minnesota Ave
Bemidji, MN 56601

Iverson Corner Drug Tdap (Tetanus, Diphtheria, Pertussis) Vaccination Screening & Informed Consent Form

Name:_____ Date of Birth:_____

Address:_____ City:_____

Phone #:_____ Zip: _____

Allergies:_____

Screening Questionnaire for Adult Tdap Immunization

	Yes	No
1. Are you sick today?	□	□
2. Do you have allergies to medication, foods, or vaccines,?	□	□
a. If so, please list _____		
3. Have you ever had a serious reaction or Guillain-Barre Syndrome after receiving a vaccine?	□	□
4. Do you have a weakened immune system caused by something such as HIV, cancer, or immunosuppressive therapy?	□	□
5. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had X-rays?	□	□
6. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin?	□	□
7. Have you ever had a Tdap vaccination?	□	□
a. If so, when? _____		
8. Women: Are you pregnant or is there a chance you could become pregnant in the next 3 months? . . .	□	□

I, the undersigned, wish to receive a vaccination against diphtheria, tetanus, and pertussis. I am taking this vaccine voluntarily and consent to the vaccination being given to me. I have read the information provided (Tdap 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
						08/06/2021