Iverson Corner Drug
408 Minnesota Ave
Bemidji, MN 56601

Iverson Corner Drug Influenza Vaccination Screening Questionnaire and Informed Consent Form

Name:_____ Date of Birth:_____

Address:_____ City:_____

Phone #:_____ Zip: _____

Allergies:_____

Screening Questionnaire for Immunizations (age 6 and up)

	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. Have you ever had a serious reaction or Guillian-Barre Syndrome after receiving a vaccine	☐	☐
4. Do you have a weakened immune system caused by something like HIV, cancer, immunosuppressive therapy or any other immune system problem?	☐	☐
5. Do you take cortisone, prednisone, other steroids, anticancer drugs, or have you had X-ray treatments for cancer?	☐	☐
6. During the past year, have you received a transfusion of blood or blood products, or been given immune(gamma) globulin?	☐	☐
7. Have you received any LIVE vaccinations in the last 4 weeks (MMR, intranasal flu, varicella, Yellow Fever)?	☐	☐
8. For 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 influenza. I am taking this vaccine voluntarily and consent to the vaccination being given to me. I have read the information provided (Influenza 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
						01/31/2025