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 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. Have you ever had a serious reaction or Guillian-Barre Syndrome after receiving a vaccine.	□	□
4. Do you have cancer, AIDS, or any other immune system problem?	□	□
5. Do you take cortisone, prednisone, other steroids, or anticancer drugs, or have you had X-ray treatments?	□	□
6. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin?	□	□
7. 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. I also understand my insurance (if applicable) will be billed but that I am responsible for any amounts not covered.

Patient Signature: _____ Date:_____

For Office Use Only

Place Lot / Exp sticker here:	Site: (R/L deltoid)	Date of Admin.	Signature of Admin/Title	Date on VIS
	R L			8/6/2021