Iverson Corner Drug
408 Minnesota Ave
Bemidji, MN 56601

Iverson Corner Drug COVID-19 Vaccination Screening Questionnaire and Informed Consent Form

Name:_____ Date of Birth:_____

Address:_____ City:_____

Phone #:_____ Zip: _____

Allergies:_____

Screening Questionnaire for COVID Immunizations (age 12 and up)

	Yes	No
1. Are you sick today?	□	□
2. Do you have allergies to medication, foods, or vaccines, (especially PEG or sucrose)?	□	□
a. (If so, please list) _____		
3. Do you have a weakened immune system caused by something such as HIV, cancer, or immunosuppressive therapy?	□	□
4. Have you ever had a heart condition (myocarditis or pericarditis) or had MIS-A or MIS-C after COVID-19 infection?	□	□
5. Have you received any COVID-19 vaccination in the past 8 weeks?	□	□
6. Women: Are you currently pregnant or breastfeeding?	□	□
7. Have you tested positive for COVID-19 in the last 2 months?	□	□
a. If so, did you receive passive antibody therapy (monoclonal antibodies or convalescent plasma)?	□	□

I, the undersigned, wish to receive a vaccination against COVID-19. I am taking this vaccine voluntarily and consent to the vaccination being given to me. I have read the information provided (COVID-19 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
						10/19/23