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

Manuf.	Lot #	Exp. Date	Site: (R/L deltoid)	Date of Admin/Date Given VIS:	Signature of Admin/Title	Date on VIS
Seqirus	P100229509	05/26/21				08/15/19

Date entered into MIIC: _____