



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
						01/31/2025