New in 2019 - Health Department Partners with Local Pharmacy for Flu Clinics

The Health Department will be partnering with a local pharmacy to offer seasonal influenza vaccination clinics to residents over the age of 55. The flu clinics will operate in the same fashion as previous clinics offered by the Health Department, except this year, pharmacists will administer the vaccinations. The available vaccines will include quadrivalent seasonal flu and high dose flu for individuals over the age of 65. The pharmacy will accept insurance billing onsite or residents can elect to self-pay and submit privately for reimbursement. Residents over the age of 55 who are uninsured and unable to self-pay may contact the Health Department at 609-936-8400 to request a voucher.
Seasonal Flu Clinics
West Windsor Township Health Department
Serving the communities of West Windsor, Robbinsville and Hightstown

Health Department announces two 2019 seasonal flu clinics for RESIDENTS over the age of 55.
WEGMAN’S PHARMACY will be onsite to provide vaccinations.

Tuesday, October 22, 2019  9:00 a.m.—1:00 p.m.
&
Tuesday, October 29, 2019  3:00 p.m.—7:00 p.m.

West Windsor Township Senior Center—Municipal Complex
271 Clarksville Rd., West Windsor, NJ 08550

Pre-registration is required!
(609) 799-9068

Private insurance, Medicare, Medicaid, and self-pay are accepted.
Vouchers are available to uninsured or underinsured residents.
Call 609-936-8400

Residents over the age of 65 will have the option to choose high-dose vaccine.

*Wear short-sleeved or loose-fitting clothing to the clinic*
*ID Required*
*Bring Insurance Card or Medicare Card*
WHAT TO BRING TO THE FLU CLINIC
Shown below are samples of items you should bring to the Flu Clinic.

ID—DRIVER’S LICENSE
OR
ID WITH ADDRESS

INSURANCE CARD
OR

MEDICARE CARD
Wegmans Pharmacy Informed Consent/Screening Questionnaire for Immunizations NJ

Name: ___________________________ Date of Birth: ___________ Age: _______ Gender: _______ Phone #: ___________

Address: ______________________ City: ___________ State: ___________ Zip: _______ Allergies: ______________________

Vaccine Type needed (circle): Influenza / Pneumonia Primary Care or other Physician: ______________________

Physician Address: ______________________

### Screening Questionnaire for Vaccination

The following questions help us determine which vaccines you may be given today. If you answer “Yes” to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your pharmacist to explain it.

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>UNKNOWN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is the person to be vaccinated sick today?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. Does the person to be vaccinated have an allergy to medications, food, a vaccine component, or latex?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. Has the person to be vaccinated ever had a serious reaction after receiving a vaccination?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. Has the person to be vaccinated had a seizure or a brain or other nervous system problem, including Guillain-Barré syndrome?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. Does the person to be vaccinated have cancer, leukemia, HIV/AIDS, or any other immune system problem?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. Females only: Is the person to be vaccinated pregnant or is there a chance they could become pregnant during the next month?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

### Medicare Part B Members Only:

**MEDICARE #: ___________________________ Part B Effective Date: ___________________________**

*(INCLUDE THE LETTER AFTER THE MEDICARE NUMBER. EXAMPLE: “555555555-A”)*

**OR**

### Insurance Information

Primary Insurance Co: ___________________________ ID#: ___________ Grp#: ___________

Policyholder Name: ___________________________ ID#: ___________

Policyholder DOB: ___________ Policyholder Address: ___________________________

I have read, or had read to me, the Vaccine Information Statement (VIS) developed by the Centers for Disease Control and Prevention (CDC) given with this Consent. I have had the opportunity to ask questions that were answered to my satisfaction. I understand the benefits and risks (including potential side effects and adverse reactions) of the vaccine(s). I consent to, or give consent for, the administration of the vaccine(s) marked below.

☐ I authorize my vaccination documentation to be forwarded to my primary care/other physician.

☐ I do not authorize my vaccination documentation to be forwarded to my primary care/other physician.

I understand and agree that if I fail to select either option 1 or 2 above that my vaccination documentation will be sent to my primary care or other physician, if identified above. I authorize my vaccination documentation to be forwarded to the collaborative prescribing physician for this program and/or the applicable State/Commonwealth Department of Health or its equivalent. I understand that it is recommended that I stay in the general area for 15 to 20 minutes after receiving my vaccination in case any immediate reactions occur. I understand that if I experience any side effects, it will be my responsibility to follow up with my physician at my expense. I hereby release the collaborative prescribing physician for this program, Wegmans Food Markets, Inc., its subsidiaries, affiliates, officers, employees and agents, from any and all liability that might arise from this vaccination on behalf of me, my heirs and personal representatives. I have been provided with a copy of the Wegmans Notice of Privacy Practices. I have been given a copy of this Consent form. Your health is very important to us. Regular preventative care, including vaccines such as the flu shot, can protect you and your family. From time to time, Wegmans Pharmacy may have helpful information regarding services that may be of interest to you. By signing below, I consent to receive healthcare communications from Wegmans Pharmacy at the telephone number(s) listed above regarding the available vaccines, my prescription(s) and those of my dependent minors, and as a follow up to care that I have received or that my dependent minors have received.

X

Patient Signature or Legal Representative

Relationship of Legal Representative to Patient (if applicable)

Date

By signing on this line, I acknowledge that I have received the immunizations listed below and authorize the release of claim information to any third party agencies involved.

<table>
<thead>
<tr>
<th>Vaccine Name</th>
<th>Dose (mL)</th>
<th>Vaccine Information</th>
<th>Route (IM/SQ/IN)</th>
<th>Site Given (RA/LA)</th>
<th>Date on VIS</th>
<th>Admin Date / Date VIS Given to Patient</th>
</tr>
</thead>
</table>

Form and Questions have been reviewed by Immunizer: Administering/Supervising Pharmacist Signature: __________ RPH

Intern Signature (if applicable): ___________________________