North Syracuse Central School District

"BRIGHTER TOGETHER"

Daniel D. Bowles
Superintendent of Schools
www.nscsd.org

January 6, 2022

Dear NSCSD Parents and Guardians,

In partnership with Kinney Drugs, the North Syracuse Central Schools has scheduled an additional COVID vaccination clinic for students aged 5-11 years-old. The clinic will be for first dose vaccinations only and will take place on January 13 from 4 PM to 6:30 PM at the Jerome F. Melvin District Office (5355 W Taft Rd, North Syracuse, NY 13212).

Parents can register their 5 to11-year-old child(ren) by clicking here. Parents that register their children for this clinic will automatically be scheduled for a second dose appointment at the District's February 3 (second dose only) clinic. There is no need to make a second dose appointment. Parents should plan to return to the District's second dose vaccination clinic at the same time on February 3.

When registering, you will be asked to provide insurance information, however, if a child is uninsured, there is no out-of-pocket cost to the family. Attached is a copy of the consent form that Kinney Drugs needs to have on file. Parents are encouraged to complete the forms in advance and bring a copy on January 13.

This initial vaccine clinic has limited vaccines available.

NSCSD will be scheduling additional COVID vaccine clinics for students aged 5-11 and update parents as details become available.

Thank you again in your ongoing support and partnership.

Sincerely

Daniel D. Bowles

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Superintendent of Schools

KinneyDrugs

Vaccine Screening and Informed Consent Form

STORE STAMP
Kinney Drugs #61
8150 Thompson Road
Cicero, NY 13039
315-699-0340 Phone
315-699-0348 Fax

SECTION A *(Please print clearly)*

Name: _____ **Date of birth:** _____ **Age:** _____ **Mother's maiden name:** _____

Gender: ☐ Female ☐ Male **Do you weigh under 110lbs?:** ☐ Yes ☐ No **Phone:** _____

Home address: _____ **City:** _____ **State:** _____ **ZIP code:** _____

Insurance Information

Name of Policy Holder: _____

Insurance name: _____

ID number: _____ **Rx Group number:** _____

BIN number: _____ **PCN:** _____ **Last 4 digits of SSN** (if Medicare eligible)**:** _____

For non-COVID -19 vaccines I agree to be fully financially responsible for any co-sharing amounts, including copays, coinsurance and deductibles, for the requested items and services as well as for any requested items and services not covered by my insurance benefits. I understand that any payment for which I am financially responsible is due at the time of service or, if KPH Healthcare Services, Inc., invoices me after the time of service, upon receipt of such invoice.

Patient initials _____ **Primary care provider name:** _____ **Phone number:** _____

Address: _____ **City:** _____ **State:** _____ ☐ *I do not have a primary care doctor*

Please add Buzzy to my vaccination. (Buzzy is a sting-free option for your vaccine. It's FREE! Ask your pharmacist!) ☐ Yes ☐ No ☐ Tell me more

SECTION B *Please complete the following questions for you or the person being vaccinated, to us determine your eligibility to be vaccinated.*

All vaccines

1.	Are you currently sick?	☐ Yes ☐ No ☐ Don't know
2.	Have you ever fainted or felt dizzy after receiving an immunization?	☐ Yes ☐ No ☐ Don't know
3.	Have you ever had an immediate allergic reaction (e.g. hives, facial swelling, difficulty breathing, anaphylaxis) to any vaccine, injection, or shot or to any component of the COVID-19 vaccine, or a severe allergic reaction (anaphylaxis) to anything?	☐ Yes ☐ No ☐ Don't know
4.	Have you ever had a reaction after receiving an immunization?	☐ Yes ☐ No ☐ Don't know
5.	In the last 10 days, have you had a COVID-19 test because you had symptoms and are still awaiting your test results or been told by a healthcare provider or health department to isolate or quarantine at home due to COVID-19 infection or exposure?	☐ Yes ☐ No ☐ Don't know
6.	Have you been treated with antibody therapy or convalescent plasma for COVID-19 in the past 90 days (3 months)? If yes, when did you receive the last dose? Date: _____	☐ Yes ☐ No ☐ Don't know
7.	Do you have a bleeding disorder, a history of blood clots or are you taking a blood thinner?	☐ Yes ☐ No ☐ Don't know
8.	Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?	☐ Yes ☐ No ☐ Don't know
9.	Do you have cancer, leukemia, HIV/AIDS or any other condition that weakens the immune system?	☐ Yes ☐ No ☐ Don't know
10.	Do you take any medications that affect your immune system, such as cortisone, prednisone or other steroids, or anti-cancer drugs, or have you had any radiation treatments?	☐ Yes ☐ No ☐ Don't know
11.	Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain-Barre syndrome or other nervous system problems?	☐ Yes ☐ No ☐ Don't know
12.	Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), or anemia or other blood disorder?	☐ Yes ☐ No ☐ Don't know
13.	For Women: Are you pregnant or considering becoming pregnant in the next month?	☐ Yes ☐ No ☐ Don't know
14.	Have you received a transfusion of blood or blood products or been given a medication called immune (gamma) globulin in the past year?	☐ Yes ☐ No ☐ Don't know
15.	Are you currently taking any antibiotics or antimalarial medications?	☐ Yes ☐ No ☐ Don't know
16.	For patients 18 years of age or younger, are you receiving aspirin therapy or aspirin-containing therapy?	☐ Yes ☐ No ☐ Don't know

SECTION C *Consent*

I certify that I am: (a) the patient and at least 18 years of age; or (b) the legal guardian of the patient. Further, I hereby give my consent to the certified-immunizing pharmacist, pharmacy intern (if permitted), registered nurse, licensed practical nurse, licensed vocational nurse, nurse practitioner, physician or physician assistant of KPH Healthcare Services, Inc., as applicable, to administer the vaccine(s) I have requested above. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine(s) and have received, read and had explained to me the Vaccine Information Statements on the vaccine(s) I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. Further, I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administering healthcare provider. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless KPH Healthcare Services, Inc., as applicable, its staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine(s) listed above. I acknowledge that the administration of an immunization or vaccine does not substitute for an annual check-up with my primary care physician. I acknowledge receipt of KPH Healthcare Services, Inc.'s privacy notice for Protected Health Information. I acknowledge that (a) I understand the purposes/benefits of my state's immunization registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) KPH Healthcare Services, Inc., as applicable, may disclose my immunization information to the State Registry, to the State HIE, or through the State HIE, to the State register, for purposes of public health reporting or to my health care providers enrolled in the State Registry and/or State HIE for purposes of care coordination. I acknowledge that, depending upon my state's law, I may prevent such disclosure, by using a state-approved opt-out form. Unless I provide KPH Healthcare Services, Inc. with a signed Op-Out Form, I understand that my consent will remain in effect until I withdraw my permission and that I may withdraw my consent by providing a completed Opt-Out Form to KPH Health Services, Inc. and/or my State HIE, as applicable. I understand that even if I do not consent or if I withdraw my consent, my state's laws may permit certain disclosures of my immunization information to or through the State HIE and/or my primary care provider listed above as required or permitted by law. I further authorize KPH Healthcare Services, Inc. to (a) release my medical or other information, including my communicable disease (including HIV), mental health and drug/alcohol abuse information, to, or through, the State HIE to my healthcare professions, Medicare, Medicaid, or other third-party payer as necessary to effectuate care or payment, (b) submit a claim to my insurer for the above requested items and services, and (c) request payment of authorized benefits be made on my behalf to KPH Healthcare Services, Inc., as applicable, with respect to the above requested items and services. I have been informed of the total cost of the immunization, subtracting any health insurance subsidization. I have been informed that if the immunization is not covered by my health insurance, that the immunization may be covered when administered by a primary care provider. ***Emergency Use Authorization for COVID Only*** *- The FDA has made the COVID-19 vaccine available under an emergency use authorization (EUA). The EUA is used when circumstances exist to justify the emergency use of drugs and biological products during an emergency, such as the COVID-19 pandemic. This vaccine has not undergone the same type of review as an FDA-approved or cleared product. However, the FDA's decision to make the vaccine available is based on the totality of scientific evidence available, showing that known and potential benefits of the vaccine outweigh the known and potential risks. Please note: FDA approved the Pfizer-BioNTech COVID-19 vaccine as a two-dose series in individuals 16 years of age and older. The vaccine continues to be available under an EUA for certain populations, including for those individuals 5 through 15 years of age and for the administration of a third dose in the populations set forth in the consent section below.*

Signature (Patient or Legal Guardian)**:** _____ **Date:** _____

Name of Legal Parent or Guardian (print)**:** _____ **Relationship to patient:** _____