Saratoga-Wilton Elks Lodge Vaccine Clinic

1 Elks Lane Saratoga Springs, NY 12866

Tuesday
10/21/25
3-6pm

Please bring all insurance cards

If 65+ please bring Medicare Part B Card

(Red, white, & blue card)

Available Vaccines

Flu (regular & 65+)

Covid

Pneumonia

Shingles

Tetanus, diphtheria, and Pertussis

RSV

BROUGHT TO YOU BY:

HANNAFORD PHARMACY
95 WEIBEL AVE, SARATOGA SPRINGS, NY 12866
(518) 587-0681

Hannaford Pharmacy Vaccine Informed Consent rev 8.2025

Store: Type: Date: Conf. #:

Name: Date of Birth: Age: Gender:

Address: City: State: Zip:

Home Phone: Mobile Phone:

Primary Care Provider: Phone Number: (NY & NH Only) Mother's maiden name:

Provider Address: I do not currently have a Primary Care Provider ☐

Race: ☐ Asian ☐ Black/African American ☐ White ☐ Other ☐Unknown ☐Native Hawaiian/Other Pacific Islander ☐American Indian/Alaskan Native

Ethnicity: ☐Unknown ☐Hispanic or Latino ☐Not Hispanic or Latino

Please indicate your preference for reporting vaccines you receive today to the state vaccine registry. If an option is not selected, vaccines will be reported to the registry. ☐ Opt In ☐ Opt Out

Screening Questionnaire. Ask or contact the pharmacist for any assistance.	Yes	No
Do you feel sick today?	☐	☐
In the past year, have you received a transfusion of blood/blood products, or been given immune globulin or antiviral drug?	☐	☐
Do you have a history of allergic reaction or allergies to vaccines, vaccine components, medications, latex, or foods?	☐	☐
Have you ever had a severe reaction to any vaccine which required medical care including fainting or feeling dizzy?	☐	☐
Have you ever received a COVID-19 vaccine? When was your last dose:	☐	☐
Have you received a vaccine in the past 4 weeks?	☐	☐
Have you ever been diagnosed with Multisystem Inflammatory Syndrome (MIS-C or MIS-A), myocarditis or pericarditis?	☐	☐
Are you receiving a hematopoietic cell transplant (HCT) or CAR-T cell therapies?	☐	☐
Do you have a chronic health condition such as heart disease, chronic lung disease, chronic kidney disease, diabetes, asthma, blood disorder, complement component deficiency, no spleen, a cochlear implant, or spinal fluid leak?	☐	☐
Have you had a seizure, brain, or any other neurological disorder, or have you had Guillain-Barré Syndrome?	☐	☐
Do you, or anyone in your home, or anyone you take care of, have a weakened immune system caused by something such as HIV/AIDS, organ transplant, cancer, currently take or have taken in the past 6 months immunosuppressive drugs or therapies? *This includes being treated with prednisone, other steroids, weekly injections, anticancer drugs, or radiation.*	☐	☐
Have you taken any antivirals (i.e. Tamiflu, valacyclovir) within the past 3 weeks?	☐	☐
Do you have a bleeding disorder, take a blood thinner, take aspirin or any aspirin-containing products, or have a history of Heparin Induced Thrombocytopenia (HIT) or thrombosis with thrombocytopenia syndrome (TTS)?	☐	☐
Do you have a parent or sibling with an immune system problem?	☐	☐
Are you pregnant, planning to become pregnant, or breastfeeding?	☐	☐

For emergency use only, please indicate the patient's weight category: ☐ <33 lbs ☐ 33-66 lbs ☐ >66 lbs

Consent: I certify that I am: (i) the Patient and at least 18 years of age; or (ii) the patient's personal representative. I consent to and request the administration of the vaccine(s) marked on this consent form by a Hannaford pharmacist, intern, or technician. I have read, or have had read to me, the Vaccine Information Statement (VIS). I understand that if a vaccine requires multiple doses, multiple doses of the vaccine will need to be administered. I, the Patient and/or the patient's personal representative, have had the opportunity to ask questions, all of which were answered to my satisfaction. I understand the benefits and risks of the vaccine(s), and I voluntarily assume full responsibility for any reactions that may result. I understand that I should remain in the vaccine administration area for at least 15 minutes and may need to remain longer (if required based on answers to screening questions above) after the vaccination to be monitored. I consent to the emergency administration of epinephrine and/or diphenhydramine, if necessary, to treat an adverse event following vaccination. I understand if I experience side effects that I should do the following: call the pharmacy, contact a doctor and/or call 911 and that it is my responsibility to follow up with my physician at my own expense. I understand that any monies or benefits for administration the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health insurance plan, Medicare, Medicaid or other third parties who are financially responsible for my medical care. I understand that Hannaford Pharmacy may be required to or may voluntarily disclose my health information as outlined in the Hannaford Notice of Privacy Practices, a copy of which can be obtained in-store, online, or by requesting a paper copy from the pharmacy. I hereby release Hannaford Pharmacy and its parent, subsidiary and affiliates, and its officers, employees, and agents, respectively, from any all liability that might arise from this vaccination on behalf of me, my heirs, and personal representatives.

Patient Name (printed): Date of Birth: Date:

Patient or Patient's Personal Representative Signature*:

Patient Guardian Name (printed): Guardian Type:

**A Personal Representative is someone who has legal authority to make healthcare decisions on the behalf of the patient*

Pharmacist Use Only Section – Location of Administration: ____________ Phone: ____________

Vaccine	Manufacturer	Dose	BUD	Site of Admin	Lot	Exp.	Diluent Lot	Diluent Exp.	VIS Date
		mL		R/L IM/SQ					
		mL		R/L IM/SQ					
		mL		R/L IM/SQ					

Vaccine Administrator Name: Title (circle one): RPh Intern PhT Date of Admin:

Vaccine Administrator Signature: Date:

Pharmacist Signature: Date:

IMPORTANT!

We ask that Patients bring their completed vaccine consent form and copies of their insurance cards with them to the clinic to streamline the process. Specifically, we need their prescription insurance card and if 65+ their Medicare Part B card (red, white, and blue card). **Please do not sign or date the form to the day of the vaccination.**

What to bring to clinic:

1. Completed vaccine consent form (wait to sign and date until the day of the clinic)
2. Prescription insurance Card
3. If 65+ Medicare Part B card (red, white, and blue card)