SENIORS, DON'T FORGET TO GET YOUR FLU SHOT

ONE ALBUQUERQUE city of albuquerque

1. SCHEDULE

- Senior Affairs will be offering flu shots between 9 a.m. & 1 p.m. at its five pick-up meal locations.

2. PLAN

- Make sure you account for travel time when planning for your visit.

3. PREPARE

- Bring your Medicare, Medicaid or private insurance card.
- **Arrive in tank top or loose fit short sleeve shirt to receive shot in your upper arm.**
- Follow the map, traffic flow, & parking instructions for your scheduled flu shot event.
- Follow all instructions given by people who are staffing the process.

THE PROCESS

- Your entire visit should take no longer than 30 minutes.
- Fill out form on the back of this flier prior to your visit if possible.
- Check-in.
- Receive flu shot.
- Remain parked in 5-minute waiting area or until you feel safe to drive.
- Exit the lot from the designated exit which is different from where you entered.

STAY SAFE

- Know the flu shot clinic entrance & exit.
- **Everyone in attendance: wear a mask with your mouth & nose covered.**
- Follow social distancing guidelines & maintain a minimum of 6 feet between you & anyone else.
- Do not eat or drink.

WHY GET A FLU SHOT?

- When more people get vaccinated against the flu, less flu can spread throughout the community.
- Helps keep more vulnerable populations from getting sick (such as children & aging parents).
- Learn more: **cabq.gov/flu**

SENIOR CENTER CLINICS

IN PARTNERSHIP WITH

ALBERTSONS MARKET PHARMACY

ALL DRIVE-THRU CLINICS:

9 a.m. - 1 p.m.

10/29/20
NORTH DOMINGO BACA
Multigenerational Center
7521 Carmel Ave NE 87113

11/6/20
NORTH VALLEY
Senior Center
3825 4th Street NW 87107

11/12/20
MANZANO MESA
Multigenerational Center
7521 Carmel Ave NE 87113

11/13/20
LOS VOLCANES
Senior Center
6500 Los Volcanes NW 87121

11/19/20
BARELAS
Senior Center
714 Seventh St SW 87108

LEARN MORE ONLINE AT CABQ.GOV/FLU

Store Number:

UNITED PHARMACY CLINICAL SERVICES
Drive-Thru Clinic Consent Form

UNITED EMPLOYEES ONLY
TM #:
STORE #:

Patient Name: _____

D.O.B._____ Age: _____ ☐ M ☐ F

Address: _____ Ph #: _____
Street City State Zip

Screening Questionnaire: Please answer the questions by checking the boxes	**Yes**	**No**
Do you feel ill today (fever/cough or shortness of breath/diarrhea >3 days/vomiting)?		
In the last 14 days, have you had contact with a lab confirmed COVID-19 patient?		
Have you ever had a serious reaction to a vaccine, eggs, or latex? If yes, please list:		
For women: Are you pregnant or are you considering becoming pregnant in the next month? Breastfeeding?		

Informed Consent: Please read and sign.

I verify that I have answered these questions to the best of my knowledge. By my signature below, I consent to the administration of the vaccine(s) by a pharmacist or a supervised student pharmacist employed by United Pharmacy and to be contacted at the number provided above regarding other immunizations for which I am due or eligible to receive. I also release United Supermarkets, LLC, and its subsidiaries, affiliates, officers, directors, employees, and agents from all liability, including acts of omission or commission, resulting or arising from my receipt of this vaccination. I understand that: 1) I have voluntarily chosen to receive the vaccination and understand that I am obligated to pay for all products and services received. 2) I may be responsible for payment after the date of service if the product or service is billed to my medical benefit. 3) I am of legal age and authorized to execute this consent form or I am not of legal age and have obtained the signed consent of a parent or guardian. 4) I will immediately alert the pharmacist of any medical conditions which may adversely affect my personal health or effectiveness of the vaccine. 5) I have been counseled about potential side effects after vaccination, when they may occur, and when and where I should seek treatment. I am responsible for following up with my physician at my expense if I experience any side effects. 6) I have been advised that I should remain in the area for 15 minutes after the vaccination for observation. 7) I have been provided access to a copy of United Supermarket Pharmacy's Notice of Privacy Practices. I have read, or have had read to me, the Vaccine Information Statement(s) ("VIS") provided for the vaccine(s) to be administered. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). 8) This vaccination, including any vaccination granted additional privacy protections under state or federal law, is subject to reporting by my pharmacy or its business associate to an immunization registry, which may share my immunization data with others, and to my primary care physician, the authorizing physician, or the local Department of Health, if applicable, and I authorize these disclosures.

Signature: _____ **Date:**_____

----------***For Pharmacy Use Only***----------

Vaccine Administered	**Lot #**	**Exp. Date**	**Site (R/L)**	**VIS Version**

Place RX Label(s) Below:

Administered By: _____

Prescription Insurance|	Insurance Name:
	BIN:
	PCN:
	Group:
	ID:
Medical Insurance|	BCBS ☐ UHC ☐ Cigna ☐ Aetna ☐
	Medical Group:
	Medical ID:
Medicare B|	ID: