Kinney Drugs COVID-19 Vaccine Clinics

For SCSD students 12 years and older, their families and SCSD staff.

A parent or legal guardian must accompany any student under the age of 18 years old.

Frazer PK-8 School

741 Park Ave. Syracuse NY 13204

1st Dose	Thursday, May 27, 3 - 7 PM
2nd Dose	Thursday, June 17, 3 - 7 PM

Grant Middle School

2400 Grant Blvd. Syracuse NY 13209

1st Dose	Wednesday, June 2, 3 - 7 PM
2nd Dose	Wednesday, June 23, 3 - 7 PM

How do I sign up?

Click for Frazer Registration

Click for Grant Registration

1. Click on the link for the corresponding school where you would like to register for a COVID-19 vaccination.
2. On the calendar click on the date of the clinic.
3. In the drop down menu, choose the time.
4. Click continue
5. Fill out all information for the person getting the vaccination.
6. Fill in insurance information or type in NA.
7. Bring identification that shows date of birth.
8. A copy of the consent form is attached for your convenience. If able, print, fill out and bring with you.

Will I need to sign up for a specific time? Yes. The clinics are from 3:00 PM-7:00 PM. Please arrive at your scheduled time.

Which vaccine will be given? The vaccine that will be given is the Pfizer vaccine only.

Will I need a second shot? Yes, you will need to schedule a second shot.

Do I need to bring ID? If you have a school ID or other form of ID, please bring it with you.

Can my parent/guardian come with me? Yes. A parent or legal guardian must accompany any student under the age of 18 years old.

What will happen when I arrive at the clinic? You will check in at registration, receive your vaccine and then must wait 15 minutes before you can leave. If you have any allergies that require an EpiPen, you will have to wait for 30 minutes after injection.

Will I receive proof that I have been vaccinated? You will receive a card showing you have been given the vaccination. It is important to keep this card in good condition and not lose it. If you can, please take a picture of it for safe keeping. You will need to bring the card with you when you return for your second shot.

What should I do before my vaccine? Hydrate and eat a good lunch.

Offered by SCSD in partnership with Kinney Drugs.

HEALTHY TOGETHER

SCSD SYRACUSE CITY SCHOOL DISTRICT

KinneyDrugs

COVID Screening and Informed Consent Form

Sections A-C to be completed by patient

SECTION A *(Please print clearly)*

Name: ____ **DOB:** ________________________

SECTION B

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 15-30 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.

Signature (Patient or Guardian)**:** ____ **Date:** ______________________

Site: ☐ Right Deltoid ☐ Left Deltoid

Date of Immunization: __________