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ST. TERESA REHABILITATION and NURSING CENTER

December 2, 2020

Hello families, residents, staff and friends,

Welcome to December. We have our Christmas decorations up. Tree in the living Room and halls are festive.

We would like to assure you that as the weather changes, we will have window visits and video calls. **We would like you to call and schedule the window visits, that we can accommodate in the living room, by the Christmas tree. As snow falls, we can not make visits at the Trinity dining room window or Trinity wing rooms safe for you. So we are arranging window visits in the living room with the outside sidewalk that we can keep safely cleared.**

Life Enrichment folks are working on photos to share with you by the tree to share our festive look. Stay tuned.

We got our testing results yesterday from 11/25 testing and we had no positive results in residents or staff. We are testing again today. We need a second week with no positive results. The positivity rate in Hillsborough County is at 9.8%. When, if it reaches 10% - we will need to test all staff 2X each week. Even if we clear outbreak status, we will not be able to allow any inside visits.

Quarantine times in the News. These changes will not affect any admissions or if a resident goes out to the hospital. For the protection of all, they will continue to be quarantined for 14 days.

- **The Covid19 Vaccine is coming our way - perhaps this month. We are working with Walgreens, who is also the parent company to our pharmacy. They have begun to share information, and if I have information I will share with you.** On our partner call with DPH today, it was shared that they want even residents and staff to receive the vaccine, since it should provide stronger protection. More on that I am sure. We will need the assent of all who will receive the vaccine, so individual or POA must assent to receive. This is a link to the Walgreens video that we received. It is about 15 minutes long. https://wba.qumucloud.com/view/oDAT0v8obvH#/ Also attached is the handout they shared. Also the consent they shared. It will just be for the Covid19 vaccine.
- More information about Covid19 vaccines can be found: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/index.html

Thanks for all your support!

Kindly,

Luanne Rogers
Administrator

COVID-19 Vaccine

What to Expect

Your trusted immunizer

Our patients have given us a consistently high satisfaction rating for our expertise, courtesy and friendliness throughout the Walgreens vaccination experience.[1] Since 2010, we've administered 60 million immunizations. And today, we continue to pave the way for pharmacy immunization services and more — rest assured, you're in great hands.

Keeping you healthy, safely

With Walgreens, your safety always comes first. We're thoroughly following the CDC recommendation for social distancing and PPE. Here's what you can expect to do when getting your vaccine:

- View vaccine safety information
- Complete applicable paperwork
- Participate in eligibility screening
- Receive your vaccination
- Take part in a 15-minute safety observation following your vaccination

Walgreens

More information ►

Personalized care for the best experience

Going the extra mile to get you the best possible care

We're extensively training over 75,000+ seasoned pharmacists and technicians to become COVID-19 specialists. With their specialized COVID-19 expertise combined with 10+ years of immunization experience, they are able to provide the highest quality care to you and your loved ones.

Working together with your facility to accommodate your needs

Our close relationship with your facility allows us to understand and tailor our care to your specific needs. We'll stay connected with staff on your schedule and any special accommodations to help you easily — and safely — get what you need.

Your questions answered

Walgreens is gathering the latest insights about COVID-19 vaccine safety and effectiveness, and common questions from our patients, all in one place. Stay up-to-date at **walgreens.com/covidvaccine**.

Reference
1. Walgreens Customer Experience Tracking Study

Walgreens

Community Off-Site Vaccine Administration Record (VAR)—Informed Consent for Vaccination

Walgreens

Please **complete Sections A, B, C** for all immunizations **prior** to the clinic date. **Medical/Pharmacy insurance (Section D)**, located on back of this form, must be **completed** if the "Off-site Clinic Billing Group" (box to the right) is blank, or as directed by your employer.	OFF-SITE CLINIC BILLING GROUP:	Store number: Store address: Rx number: _____

SECTION A Please print clearly.

First name: _____ **Last name:** _____

Date of birth: _____ **Age:** _____ **Gender:** ☐ Female ☐ Male **Phone:** _____

Home address: _____ **City:** _____

State: _____ **ZIP code:** _____ **Email address:** _____

Walgreens will send vaccination information from this visit to your doctor/primary care provider using the contact information provided below.

Doctor/primary care provider name: _____ **Phone:** _____

Address: _____ **City:** _____ **State:** _____ **ZIP code:** _____

I want to receive the following vaccination(s): _____

SECTION B The following questions will help us determine your eligibility to be vaccinated today.

	All vaccines			
1.	Do you feel sick today?	☐ Yes	☐ No	☐ Don't know
2.	Do you have any health conditions, such as heart disease, diabetes or asthma? If yes, please list: _____	☐ Yes	☐ No	☐ Don't know
3.	Do you have allergies to latex, medications, food or vaccines (examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)? If yes, please list: _____	☐ Yes	☐ No	☐ Don't know
4.	Have you ever had a reaction after receiving a vaccination, including fainting or feeling dizzy?	☐ Yes	☐ No	☐ Don't know
5.	Have you ever had a seizure disorder for which you are on seizure medication(s), a brain disorder, Guillain-Barré syndrome (a condition that causes paralysis) or other nervous system problem?	☐ Yes	☐ No	☐ Don't know
6.	**For women:** Are you pregnant or considering becoming pregnant in the next month?	☐ Yes	☐ No	☐ Don't know
	For chickenpox, MMR® II, shingles, yellow fever only: Only answer these questions if you are receiving any vaccinations listed above.			
7.	Have you received any vaccinations or skin tests in the past four to eight weeks? If yes, please list: _____	☐ Yes	☐ No	☐ Don't know
8.	Do you have a condition that may weaken your immune system (e.g., cancer, leukemia, lymphoma, HIV/AIDS, transplant)?	☐ Yes	☐ No	☐ Don't know
9.	Are you currently on home infusions, weekly injections such as Humira® (adalimumab), Remicade® (infliximab) or Enbrel® (etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?	☐ Yes	☐ No	☐ Don't know
10.	Are you currently taking high-dose steroid therapy (prednisone > 20mg/day or equivalent) for longer than 2 weeks?	☐ Yes	☐ No	☐ Don't know
11.	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
12.	Do you have a history of thymus disease (including myasthenia gravis, DiGeorge syndrome or thymoma), or had your thymus removed? (yellow fever only)	☐ Yes	☐ No	☐ Don't know
13.	Do you have a history of thrombocytopenia or thrombocytopenia purpura? (MMR® II only)	☐ Yes	☐ No	☐ Don't know

SECTION C

I certify that I am: (a) the patient and at least 18 years of age; (b) the parent or legal guardian of the minor patient; or (c) the legal guardian of the patient. Further, I hereby give my consent to Walgreens or Duane Reade and the licensed healthcare professional administering the vaccine, as applicable (each an "applicable Provider"), 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/or 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 observation for approximately 15 minutes after administration. On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless each applicable Provider, 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: (a) I understand the purposes/benefits of my state's vaccination registry ("State Registry") and my state's health information exchange ("State HIE"); and (b) the applicable Provider may disclose my vaccination information to the State Registry, to the State HIE, or through the State HIE to the State Registry, for purposes of public health reporting, or to my healthcare 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, by using a state-approved opt-out form or, as permitted by my state law, an opt-out form ("Opt-Out Form") furnished by the applicable Provider: (a) the disclosure of my vaccination information by the applicable Provider to the State HIE and/or State Registry; or (b) the State HIE and/or State Registry from sharing my vaccination information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. The applicable Provider will, if my state permits, provide me with an Opt-Out Form. I understand that, depending on my state's law, I may need to specifically consent, and, to the extent required by my state's law, by signing below, I hereby do consent to the applicable Provider reporting my vaccination information to the State HIE, or through the State HIE and/or State Registry to the entities and for the purposes described in this Informed Consent form. Unless I provide the applicable Provider with a signed Opt-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 the applicable Provider 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 vaccination information to or through the State HIE as required or permitted by law. I also authorize the applicable Provider to disclose my, or my child's (or unemancipated minor for whom I am authorized to act as guardian or in loco parentis), proof of vaccination to the school where I am, or my child (or unemancipated minor for whom I am authorized to act as guardian or in loco parentis) is, a student or prospective student. I further authorize the applicable Provider 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 professionals, 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 the applicable Provider with respect to the above requested items and services. I further agree to be fully financially responsible for any cost-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 the applicable Provider invoices me after the time of service, upon receipt of such invoice.

Patient signature: _____ **Date:** _____
(Parent or guardian, if minor)

SECTION D INSURANCE – PATIENT TO COMPLETE IF APPLICABLE

Please ensure to record BOTH pharmacy AND medical insurance information since there are multiple ways immunizations can be billed at Walgreens.

	Pharmacy Card	Medical Card
Insurance Plan/Plan ID:		
Member/Recipient ID Number:		
RX BIN:		N/A
RX PCN:		N/A
Group Number:		

Are you the cardholder? ☐ Yes ☐ No

If no, please provide cardholders name, date of birth (MM/DD/YYY) and relationship: _____

SECTION E HEALTHCARE PROVIDER ONLY

Complete BEFORE vaccine administration

1. I have reviewed the **Patient Information** and **Screening Questions.** Initial here: _____
2. I have verified that this is the **vaccine requested** by the patient. Initial here: _____
3. This vaccine is appropriate for this patient based on the **Age Guidelines** provided by federal and/or state regulations and company policies. Initial here: _____

   3a. Does this patient have a high-risk medical condition? ☐ Yes ☐ No

   If yes, please list medical condition(s): _____
4. The **Vaccine NDC matches** the NDC on the bottom of this VAR form and the NDC on the patient leaflet. (Perform **3-way NDC match**.) Initial here: _____
5. I have verified the **Expiration Date** is greater than today's date and have entered the **Lot # and Expiration Date** in the field below. Initial here: _____

For Shingrix®, Zostavax®, MMR® II, Varivax®, YF-Vax®, Menveo®, Imovax® and RabAvert®, ensure the vaccine is reconstituted following the package insert's instructions.

Lot #: _____ Expiration Date: _____

For vaccines that have a diluent, complete the following:

Lot #: _____ Expiration Date: _____

SECTION F

Complete DURING the patient interaction

1. I have asked the patient to confirm their **Name, DOB and Requested Vaccine** and verified it matches the information on the VAR form. Initial here: _____
2. I have reviewed the **Screening Questions** with the patient. Initial here: _____
3. I have reviewed the **VIS** with the patient. Initial here: _____

SECTION G

Complete AFTER vaccine administration

Vaccine	NDC	Manufacturer	Dosage	Site of administration	VIS published date

Clinician's name (print): _____ **Clinician's signature:** _____ **Title:** _____

If applicable, intern name (print): _____ **Administration date:** _____ **Date VIS given to patient:** _____

Notes

Reminder

1. Update the patient's record with any new allergy, health condition or primary care provider information.
2. Enter vaccine lot #, expiration date and site of administration, then scan the VAR form into the patient's record.