IT’S THAT TIME AGAIN
Time to get your FREE flu shot

Miami-Dade County Employees GET A FREE FLU VACCINE:
At one of the MDC facilities listed on the next page,

OR

• Your Physician’s Office
  When the sole purpose of your visit is to get a flu shot, you won’t pay a cent.
• Participating Pharmacies
  You don’t need a prescription, and at many pharmacies, you can walk in without an appointment.
• Retail Clinics

Flu season is here again and the best way to prevent getting the flu is by getting your vaccination. It’s easy and it’s FREE when you present your AvMed ID card and another form of identification.
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
<th>Location\Time</th>
<th>Screenings</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/24/15</td>
<td>Health Fair &amp; Flu Vaccines</td>
<td>Parks Zoo Miami - 10 AM to 2 PM &lt;br&gt; Zoo Miami’s Staff entrance Gate 3, ZSF</td>
<td>Health Screenings - Blood Pressure, Total Cholesterol/HDL Ratio, Glucose, BMI, Chair Massage</td>
</tr>
<tr>
<td>10/1/15</td>
<td>Flu Vaccines</td>
<td>SPCC - 10 AM to 3 PM &lt;br&gt; 111 NW 1st Street, 18-4</td>
<td>Flu shots only</td>
</tr>
<tr>
<td>10/2/15</td>
<td>Flu Vaccines</td>
<td>Transit Central Garage - 10 AM to 12 PM &lt;br&gt; 3300 NW 32 Avenue, Driver’s Room, 1st Floor</td>
<td>Flu shots only</td>
</tr>
<tr>
<td>10/6/15</td>
<td>Flu Vaccines</td>
<td>So. Dade Govt. Ctr. - 10 AM to 1 PM &lt;br&gt; 10710 SW 211 St., Rm 104</td>
<td>Flu shots only</td>
</tr>
<tr>
<td>10/7/15</td>
<td>Health Fair &amp; Flu Vaccines</td>
<td>Police HQ - 10 AM to 2 PM &lt;br&gt; 9105 NW 25 St, Cafetorium</td>
<td>Health Screenings - Blood Pressure, Total Cholesterol/HDL Ratio, Glucose, BMI, Chair Massage</td>
</tr>
<tr>
<td>10/8/15</td>
<td>Health Fair &amp; Flu Vaccines</td>
<td>OTV - 10 AM to 2 PM &lt;br&gt; 701 NW 1st Court, 1st Floor Training Rm</td>
<td>Health Screenings - Blood Pressure, Total Cholesterol/HDL Ratio, Glucose, BMI, Chair Massage</td>
</tr>
<tr>
<td>10/9/15</td>
<td>Health Fair &amp; Flu Vaccines</td>
<td>Seaport - 11 AM to 3 PM &lt;br&gt; 1015 North America Way, 2nd FL Conf Rm</td>
<td>Health Screenings - Blood Pressure, Total Cholesterol/HDL Ratio, Glucose, BMI, Chair Massage</td>
</tr>
<tr>
<td>10/13/15</td>
<td>Health Fair &amp; Flu Vaccines</td>
<td>Permitting &amp; Inspection Center - 7:30 AM to 11:30 AM &lt;br&gt; 11805 SW 26th St. Conf RM I/J</td>
<td>Health Screenings - Blood Pressure, Total Cholesterol/HDL Ratio, Glucose, BMI, Chair Massage</td>
</tr>
<tr>
<td>10/14/15</td>
<td>Health Fair &amp; Flu Vaccines</td>
<td>Water &amp; Sewer - 10 AM to 2 PM &lt;br&gt; Douglas HQ - 3071 SW 38th Ave Room # 156A</td>
<td>Health Screenings - Blood Pressure, Total Cholesterol/HDL Ratio, Glucose, BMI, Chair Massage</td>
</tr>
<tr>
<td>10/16/15</td>
<td>Flu Vaccines</td>
<td>Transit NE Garage - 10 AM - 12 PM &lt;br&gt; 360 NE 185 St., Driver’s Room 1st Floor</td>
<td>Flu shots only</td>
</tr>
<tr>
<td>10/20/15</td>
<td>Health Fair &amp; Flu Vaccines</td>
<td>Aviation - 10 AM to 2 PM &lt;br&gt; MIA, Concourse D Auditorium, 4th Floor</td>
<td>Health Screenings - Blood Pressure, Total Cholesterol/HDL Ratio, Glucose, BMI, Chair Massage</td>
</tr>
<tr>
<td>10/21/15</td>
<td>Flu Vaccines</td>
<td>Transit Lehman Center - 9 AM to 11 AM &lt;br&gt; 6601 NW 72 Ave, Conf Rm A</td>
<td>Flu shots only</td>
</tr>
<tr>
<td>10/28/15</td>
<td>Health Fair &amp; Flu Vaccines</td>
<td>ITD 10 AM-2 PM &lt;br&gt; 5680 SW 87 Ave, 2nd Floor Break Rm</td>
<td>Health Screenings - Blood Pressure, Total Cholesterol/HDL Ratio, Glucose, BMI, Chair Massage</td>
</tr>
<tr>
<td>10/30/15</td>
<td>Flu Vaccines</td>
<td>Transit Coral Way -10 AM to 12 PM &lt;br&gt; 2775 SW 74 Ave., Driver’s Room, 1st Floor</td>
<td>Flu shots only</td>
</tr>
</tbody>
</table>
Vaccine Administration Record (VAR) - Informed Consent for Vaccination

Section A
Complete a separate VAR for each administered vaccine

Patient First Name: ___________________________  Patient Last Name: ___________________________

Date of Birth: ___________________________  Age: ___________________________  Gender: □ Female  □ Male  Phone Number: ___________________________

City: ___________________________  State: ___________________________  Zip: ___________________________

Home Address: ___________________________

Email Address: ___________________________

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 the healthcare provider of Walgreens, Duane Reade, Take Care Health Services, or DHR Walk-in Medical Care, as applicable (each an “Applicable Provider”), to administer the vaccine(s) I have requested. I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccines. 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 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 the 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 (i) I understand the purposes/benefits of my state’s immunization information registry (“State Registry”) and my state’s health information exchange (“State HIE”), or the applicable provider may disclose my immunization information to the State Registry, to the State HIE, or through the State HIE, 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, by using a state-approved opt-out form or, as permitted by the state law, an opt-out form (“Opt-Out Form”) furnished by the Applicable Provider: (a) the disclosure of my immunization 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 immunization information with any of my other healthcare providers enrolled in the State Registry and/or State HIE. The applicable provider shall, if I sign this form, 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 immunization 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 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 immunization 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 unmanipulated minor for whom whom I am authorized to act as guardian or in loco parentis) proof of immunization to the State HIE, or through the State Registries, to the entity and name or number or address of the state, or through, the State HIE to my healthcare professionals, Medicare, Medicaid, or other third-party payer as necessary to affectuate care or payment, (b) submit a claim to my insurer for the above requested items and services, and (c) request payment of authorized benefits to 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 due to the time of service or the applicable provider invoices me after the time of service, upon receipt of such invoice.

Patient Signature: ___________________________

Date: ___________________________

*Healthcare providers can be an immunization-certified pharmacist or a registered nurse, licensed practical nurses, licensed vocational nurses, nurse practitioner, physician or physician’s assistant **Patient care services at Healthcare Clinic at select Walgreens provided by Take Care Health Services, an independently owned professional corporation whose licensed healthcare professionals are not employed by or agents of Walgreens Co. or its subsidiaries, including Take Care Health Systems, LLC, Walgreens Co. and its subsidiary companies provide management services to provider practices, in-store clinics and worksite health and wellness centers.

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Section D - Complete BEFORE Vaccine Administration

1. I have reviewed the Patient Information and Screening Questions. Initial here: __________

2. 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, state regulations and company policies. Initial here: __________

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: __________

  Lot #: __________________________

  Expiration Date: ______________________

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

Section E - 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 F - Complete AFTER Vaccine Administration

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>NDC</th>
<th>Manufacturer</th>
<th>Dosage</th>
<th>Site Of Administration</th>
<th>VIS published date</th>
</tr>
</thead>
</table>

Immunizer Name (print): __________________________ Immunizer Signature: __________________________ Title: __________________________

If applicable, Intern’s Name (print): __________________________ Administration Date: __________ Date VIS given to patient: __________

Reminder:

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