Walmart and Sam's Club Vaccine Administration Record and Informed Consent

Walmart

Section A *(please print clearly)*

First Name: ____________________ Last Name: ____________________ Sex assigned at birth: ☐ Female ☐ Male

Date of Birth: ____________________ Home Address: ____________________

City: ____________________ State: ________ Zip: ____________ Phone Number: ____________________

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

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic or Latino ☐ Decline to State

Do you have a Primary Care Physician? (PCP) ☐ YES ☐ NO PCP Name: ________________ Street Name: ____________

Do you authorize this pharmacy to send your information to your PCP? (info must be sent to PCP in Arizona) ☐ YES ☐ NO

Vaccine(s) Requested: ______________________________

1.Is the person to be vaccinated sick or injured today? If Yes, new fever, a cough, diarrhea, or vomiting? YES NO
Does the person have an open wound, puncture, or tissue tear that prompted a tetanus shot? YES NO

2. Does the person have allergies to medications, food components, vaccine components, or latex? YES NO
If yes, please list:______________ *Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast, thimerosal*

3. Does the person have a chronic health condition or long-term health problem? YES NO
Examples: heart, lung, kidney, neuromuscular, neurologic, liver, metabolic diseases, asthma, diabetes, anemia, other blood disorders

4. Has the person ever had a reaction, fainted, or felt dizzy after receiving a vaccine, have a history of thrombocytopenia, or has any physician or other healthcare professional ever cautioned or warned about receiving certain vaccines or receiving vaccines outside of a physician's office or hospital? YES NO

5. Has the person ever had a seizure disorder for which they are on seizure medications, a brain disorder, Guillain-Barre Syndrome, or other nervous system problems? YES NO

6. Is the person currently pregnant or considering becoming pregnant in the next month? YES NO

7. Does the person have a weakened immune system or been told by a physician that they are immunosuppressed? YES NO
Examples: cancer, leukemia, lymphoma, HIV/AIDS, transplant, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease, or other immune system disorder

8. Has the person received any vaccinations or skin tests in the past four weeks? YES NO

9. Is the person currently on medications that weaken the immune system? YES NO
Examples: Remicade, Humira, Enbrel, Cimzia, Simponi, Simponi Aria, Xeljanz, Orencia, Arava, Actemra, Cytoxan, Rituxan, adalimumab, infliximab or etanercept, high dose methotrexate, azathioprine, mercaptopurine, anticancer drugs, antivirals or radiation treatment, cortisone or high-dose steroid therapy (prednisone >20mg/day or equivalent) for longer than two weeks?

10. Has the person received a transfusion of blood or blood products or been given immune (gamma) globulin in the past year? YES NO

Section B *Please read the section below carefully and sign and date acknowledging that you understand and agree.*

I consent to vaccine administration by Walmart or Sam's Club, its employees (pharmacist, qualified pharmacy technician or state authorized pharmacy intern), contractors, or agents. I received the Vaccine Information Statement or Patient Fact Sheet for the vaccine(s). The risks and benefits were explained to me. My questions were answered to my satisfaction. I was advised to remain near the vaccination area for 15 minutes after administration for observation. On behalf of myself or the patient named above, I release and discharge Walmart, Inc. or Sam's Club, Inc., from any and all liabilities or claims whether known or unknown arising in any way related to the administration of the vaccine(s) listed above. **Initials:** _______

Disclosure of Records: I acknowledge and consent to the reporting of this vaccine administration to any required local, state, or federal health authorities. Depending on state law, I may be able to Opt-Out of the disclosure of my information to the state registry by completing an approved form. **Initials:**_____

Payment Authorization: I assign payment of authorized insurance benefits due to me to be paid to the pharmacy. **Initials:** ______

Notices: I acknowledge receipt of Walmart or Sam's Club Health & Wellness Notices. I understand that the Notice is subject to change, and I can obtain a current Notice online at www.walmart.com, www.samsclub.com, or at any local store or club location.
Refusing to initial and acknowledge receipt will have no impact on my treatment. **Initials:** ________

Patient: ☐ Legally Authorized Representative: ☐ Relationship: ____________________

Name:________________________ **Signature:**______________________________ **Date:** __________

Section C The following section is to be completed by a health care provider ONLY.

Pharmacy Verification: Patient name ☐ Patient age _________ Vaccine DUR ☐ Manual Reporting Initials: ____ Date:______ Time: _________

Pharmacist Name (Print): ______________________________ Pharmacist Signature:______________________________

Administering Individual Name and Title (Print): ____________________ Administration Date/Date VIS Given: ______________

Vaccine	Lot #	Exp. Date	Manufacturer	NDC	Dosage	Site	Route	VIS Date	RPh Initials
						LA RA NAS	SQ IM NAS		
						LA RA	SQ IM		
						LA RA	SQ IM		
						LA RA	SQ IM		

Insurance Attestation Form

Date: ____________________

Patient Name (First & Last): ____________________ Phone Number: ____________________

Section A: Insurance Coverage Information

Please provide **all applicable** insurance information below. *FOR COVID-19 IMMUNIZATIONS ONLY: If you have no active insurance coverage, skip section A and complete section B below.*

Note: For active insurance coverage, but unsure of your insurance information, provide the last 4 digits of your Social Security Number. (Last 4 digits of SSN) - ____________________

1. ***Pharmacy Insurance Information:***
   Insurance Carrier: ____________________ Patient ID: ____________________
   Primary Cardholder (Y/N): ______ Dependent Number: ____________________
   BIN: ____________ PCN: ____________ Group: ____________________

2. ***Medical Insurance Information:***
   Insurance Carrier: ____________________ Patient ID: ____________________
   Group: ____________________ Payer ID: ____________________

3. ***Medicare Insurance Information (RED, WHITE & BLUE CARD):***
   Name (as it appears on the card): ____________________
   Medicare ID #: ____________________