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

Section A *(please print clearly)*

irst Name: _____ Last Name: _____ Sex assigned at birth: [1Female [Male

Date of Birth(MM/DD/YYYY): _____ Home Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

{ace: D American Indian/Alaskan Native □Asian D Black/African American D White D Native Hawaiian/Other Pacific Islander C Other D Decline to State

:thnicity: D Hispanic/Latino D Not Hispanic or Latino □Decline to State

)o you have a Primary Care Physician? (PCP) DYES □NO PCP Name: _____ Street Name: _____

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

.raccine(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: _____ *Example5: egg5, bovine protein, gelatin, gentomicin, polymyxin, neomycin, phenol, yea5t, thimerosol*
3. Does the person have a long-term health problem or are they taking a blood thinner? YES NO
   Examples: heart, lung, kidney, neuromuscular, neurologic, liver, metaboficdiseoses, asthma, diabetes, anemia, other blood disorder5, or taking a blood thin11er
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 eroblems? 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 oast vear? 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. **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 completinp, 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: D Legally Authorized Representative: D Relationship: _____

Name: _____ **Signature:** _____ **Date:** _____

iection C The following section Is to be comeleted b a health care erovider ONLY.

Iharmacy Verification: Patient name o Patient age _____ Vaccine DUR o Manual Reporting Initials: _ _ Date:_ _ _ Time: _____

>harmacist Name (Print): _____ Pharmacist Signature: _____

\dministering Individual Name and Title (Print): _____ Administration Date/Date VIS Given: _____

Vaccine	Lot/I	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		