IN-STORE USE ONLY Walmart and Sam's Club Vaccine Administration Record and Informed Consent

Section A *(please print clearly)*

First Name: _____ Last Name: _____ Gender: ☐ Female ☐ Male Date of Birth: _____

Race/Ethnicity: _____ Mother's Maiden Name _____

Home Address: _____ City: _____ State: _____ Zip: _____ Phone Number: _____

Walmart/Sams will send immunization information from this visit to your Primary Care Provider using the contact information provided below.

Do you have a Primary Care Provider? ☐ NO ☐ YES Primary Care Provider Name: _____ Street Name: _____

Vaccine Requested:

☐ Flu ☐ Pneumococcal ☐ Shingles ☐ Tdap ☐ Td ☐ MMR ☐ HepA ☐ HepB ☐ Meningococcal ☐ Varicella ☐ HPV

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

Questions 1 through 6 below pertain to all vaccines. *The questions below will allow us to determine your eligibility to receive vaccines.*

1. Is the person to be vaccinated feeling sick today or do they have a moderate to high fever? **Pharmacist Initials:** _____	YES	NO
2. Does the person to be vaccinated have allergies to medications, food components, vaccine components, or latex? *Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast, thimerosal*	YES	NO
3. Does the person to be vaccinated have a chronic condition or long term health problem? *Examples: heart disease, lung disease, asthma, kidney disease, diabetes, anemia, other blood disorders, or is the patient a smoker?*	YES	NO
4. Has the person to be vaccinated ever had a serious reaction after receiving an immunization?	YES	NO
5. Has the person to be vaccinated ever had a seizure disorder, brain disorder, or Guillain-Barre Syndrome, or a nervous system problems?	YES	NO
6. Is the person to be vaccinated currently pregnant, considering becoming pregnant in the next month , or breast-feeding?	YES	NO

Please also answer the questions below if you will be receiving a LIVE vaccine (varicella, measles/mumps/rubella (MMR II), shingles).

7. Has the person to be vaccinated received any vaccinations or skin tests in the past four weeks	YES	NO
8. Does the person to be vaccinated have weakened immune system or is in contact with anyone with a severely weakened immune system? *Examples: cancer, leukemia, lymphoma, HIV/AIDS, transplant or any other immune system disorder*	YES	NO
9. Is the person to be vaccinated currently on home infusions, weekly injections, steroid therapy, anticancer drugs, antivirals or radiation treatment?	YES	NO
10. Has the person to be vaccinated received a transfusion of blood or blood products, or been given immune (gamma) globulin during the past year?	YES	NO
11. Does the person to be vaccinated have a history of thrombocytopenia or thrombocytopenia purpura (MMR II only)	YES	NO

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

I hereby give my consent to Walmart, as applicable, to administer the medications(s) I have requested above. I understand the benefits and risks of receiving this medication and have received, read and/or had explained to me the Vaccine Information Statement on the vaccine(s) I have elected to receive. I acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction. I acknowledge that I have been advised to remain near the vaccination location for approximately 20 minutes after administration for observation by the administering healthcare provider. On behalf of myself, my heirs, and personal representatives, I fully release and discharge Walmart , its staff, agents, successor, division, affiliates, officers, directors, contractors, and employees 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:** _____

I understand the purposes/benefits of my state's immunization registry and acknowledge that, depending upon my state law, I may prevent disclosure of my immunization to the state registry with a signed Opt-Out. **Initials:** _____

I assign payment of authorized insurance benefits due to me to be paid to the pharmacy. I consent to the release of medical information when necessary for billing, reimbursement, and medical protocol. **Initials:** _____

I am aware an immunization certified student pharmacist might be administering this medication. **Initials:** _____

Parent/Legal Guardian/Patient Name: **Signature:** **Date:**

Section D *The following section is to be completed by the health care provider only.*

Immunizing Pharmacist Name (print) _____ Immunizing Pharmacist Signature _____

Intern Name (print) _____ Administration Date/Date VIS Given: _____

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

☐ Standing Order Physician ☐ Automated Reporting

☐ Prescribing Pharmacist Name: _____ ☐ Manual Reporting Intitials: _____ Date: _____ Time: _____

☐ Patient Specific Prescription Physician Name _____ Fax: _____