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: _____

Standing Order: Automated Reporting unless documented below.
•Manual Reporting (Twinrix, Prescription)
Initials/Date/Time_____

APPENDIX C – Patient Health Questionnaire & Consent Form Supplement – All Vaccines

General Screening: The Pharmacist MUST ask the following questions to determine the safety of all vaccines to be given	**Yes**	**No**
1. Are you sick today?		
If Question 1. Answer is yes:		
A. Do you have a new fever?		
B. Do you have a cough?		
C. Do you have diarrhea?		
D. Have you been vomiting?		
2. Have you ever fainted or felt dizzy after receiving a vaccine?		
3. Have you ever had a reaction after receiving a vaccine?		
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, neurologic or neuromuscular disease, liver disease, metabolic disease (e.g., diabetes),or anemia or another blood disorder?		
5. Do you have a weakened immune system because of HIV/AIDS or another disease that affects the immune system, long-term treatment with drugs such as high-dose steroids, or cancer treatment with radiation or drugs?		
6. Do you have allergies to latex, medications, food or vaccines? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)		
7. Have you ever had a seizure disorder for which you are on seizure medications, a brain disorder, Guillain-Barré syndrome or other nervous system problems?		
8. For women: Are you pregnant or considering becoming pregnant in the next month?		

APPENDIX D- Patient Health Questionnaire & Consent Form Supplement – Live Vaccines

General Screening: The Pharmacist must as the following questions to determine the safety of live vaccines to be given	**Yes**	**No**
1. Are you currently on home infusions or weekly injections (such as Remicade, Humira, Enbrel, Cimzia, Simponi, Simponi Aria, Xeljanz, Orencia, Arava, Actermra, Cytoxan, Rituxan, adalimumab, infliximab or etanercept), high-dose methotrexate, azathioprine or 6-mercaptopurine, antivirals, anticancer drugs or radiation treatments?		
2. Have you received any vaccinations or skin tests in the past four weeks?		
3. Have you received a transfusion of blood, blood products or been given a medication called immune (gamma) globulin in the past year?		
4. Are you currently taking high-dose steroid therapy (prednisone >20mg/day or equivalent) for longer than two weeks?		