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

## 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:** (circle one) FLU COVID FLU & COVID

| | |
|---|---|
| 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? If yes, please list: _____ *Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast, thimerosal* | YES NO |
| 3. Does the person have a chronic health condition or long-term health problem? *Examples: heart, lung, kidney, neuromuscular, neurologic, liver, metabolic diseases, asthma, diabetes, anemia, other blood disorders* | YES NO |
| 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? *Examples: cancer, leukemia, lymphoma, HIV/AIDS, transplant, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease, or other immune system disorder* | YES NO |
| 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? 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? | YES NO |
| 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.

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

1 ***MEDICAL INSURANCE Information:***

***Insurance Carrier:*** _____ Patient ID:_____

***Group:*** _____ Payer ID:_____

2 ***Pharmacy Insurance Information:*** Insurance Carrier: _____ Primary Patient ID:_____

Cardholder (Y/N) _____ Dependent Number_____

BIN:_____ PCN:_____ Group:_____

3 ***Medicare Insurance Information (RED, WHITE & BLUE CARD):***

Name (as it appears on the card): _____

Medicare ID #: _____

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## Section B: Long Term Care Facility (LTCF) Clinic - *Place of Service Confirmation*

Complete the section ONLY if you are receiving an immunization at a LTCF.

Place a check next to the administration setting below in which you are receiving your vaccination to ensure we correctly file the claim for your vaccination service.

☐Communal Setting at the Long Term Care Facility **(no reason or signature required)**

☐Patient Room **(reason and signature required below)**

- I confirm that the vaccination service was provided in my patient room as indicated below.

Reason: _____

Patient Signature: _____