

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

Walmart



Dr. Kelly, P. NPI:1982869467 413-668-6684 1 Cooper Plaza Camden, NJ 08103

Manual Reporting Initials:

Date:

Time:

## Section A (please print clearly)

Pharmacist Verification: ☐ Patient Name ☐ Patient DOBFirst Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Gender: ☐ 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 StateEthnicity: ☐ Hispanic/Latino ☐ Not Hispanic or Latino ☐ Decline to StateDo you have a Primary Care Physician? ☐ YES ☐ NO Primary Care Physician Name: \_\_\_\_\_ Street Name: \_\_\_\_\_Do you authorize this pharmacy to send your information to your Primary Care Physician? ☐ YES ☐ NO

Vaccine Requested: Flu COVID-19 Pneumococcal Shingles Tdap Td MMR HepA HepB Meningococcal Varicella HPV

## Section B Questions (1-7) below pertain to all vaccines and will help us determine your eligibility to be vaccinated today.

Pharmacist Verification of DURs ☐

1. Is the person to be vaccinated sick or injured today? If Yes, \_\_\_\_\_ YES NO

a. Does the person have a new or moderate to high fever? \_\_\_\_\_ YES NO

b. Does the person have a cough? \_\_\_\_\_ YES NO

c. Does the person have diarrhea? \_\_\_\_\_ YES NO

d. Has the person been vomiting? \_\_\_\_\_ YES NO

e. Do you have a cut, injury, puncture, or open wound that prompted you to get a tetanus shot? \_\_\_\_\_ YES NO

Pharmacist initials after reviewing with patient: \_\_\_\_\_

2. Does the person to be vaccinated have allergies to medications, food components, vaccine components, or latex? If yes, please list. \_\_\_\_\_ YES NO

Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast, thimerosal

3. Does the person to be vaccinated have a chronic health condition or long-term health problem? \_\_\_\_\_ YES NO

Examples: heart, lung, kidney, neuromuscular, liver, metabolic diseases, asthma, diabetes, anemia, other blood disorders, neurologic or is the patient a smoker?

4. Has the person to be vaccinated ever had a reaction, fainted, or felt dizzy after receiving a vaccine or has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting? \_\_\_\_\_ YES NO

5. Has the person to be vaccinated 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 to be vaccinated currently pregnant, considering becoming pregnant in the next month, or breast-feeding? \_\_\_\_\_ YES NO

7. Does the person to be vaccinated have a weakened immune system, is in contact with anyone with a severely weakened immune system or in long-term treatment with drugs such as high-dose steroids? Examples: cancer, leukemia, lymphoma, HIV/AIDS, transplant, rheumatoid arthritis, ankylosing spondylitis, Crohn's disease or any other immune system disorder? \_\_\_\_\_ YES NO

## For persons in North Carolina, OR if the person will be receiving COVID-19, varicella, measles/mumps/rubella (MMR II), shingles, answer questions (8-11) below.

8. Has the person to be vaccinated received any vaccinations or skin tests in the past four weeks? \_\_\_\_\_ YES NO

9. Is the person to be vaccinated currently on home infusions, weekly injections (such as 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 to be vaccinated received antibodies, a transfusion of blood or blood products, been given immune (gamma) globulin, or antivirals in 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 and/or Vaccine Patient Fact Sheet for 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, acknowledge, and consent that the administration of this vaccine will be entered into my state's immunization registry. 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. The Pharmacist has informed me that I may have the right to refuse. I acknowledge that the administration of this vaccine will be reported to any required local, state, or federal health authorities. 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 a pharmacist, qualified pharmacy technician or state authorized pharmacy intern, as allowed by law, might be administering this medication. Initials: \_\_\_\_\_

By initialing here, I acknowledge receipt of Walmart/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](http://www.walmart.com), [www.samsclub.com](http://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/Legal Guardian Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

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		