

**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:** \_\_\_\_\_

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: \_\_\_\_\_ Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast, thimerosal
3. Does the person have a chronic health condition or long-term health problem? YES NO  
 Examples: heart, lung, kidney, neuromuscular, neurologic, liver, metabolic diseases, asthma, diabetes, anemia, other blood disorders
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? 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 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		