OFFSITE EVENT USE Walmart and Sam's Club Vaccine Administration Record and Informed Consent

	Standing Order Physician		Automated Reporting
	Prescribing Pharmacist Name:		Manual Reporting Initials: Date: Time:
	Patient Specific Prescription – Physician Name:		Fax:

Section A *(please print clearly)* Pharmacist Verification: ☐ Patient Name ☐ Patient DOB

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

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

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

Insurance Carrier:_____ **Patient ID #**_____ **BIN #**_____ **PCN #**_____ **GROUP#**_____

Do you authorize this pharmacy to send your information to your Primary Care Physician? YES ☐ NO ☐

Vaccine Requested: Flu ☐ Pneumococcal ☐ Shingles ☐ Tdap ☐ Td ☐ MMR ☐ HepA ☐ HepB ☐ Meningococcal ☐ Varicella ☐ HPV ☐ IPV ☐

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 to be vaccinated will be receiving varicella, measles/mumps/rubella (MMR II), shingles, answer questions (8-11)

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, Actermra, 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 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 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 and acknowledge 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. **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:** _____

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, 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.*

Immunizer Name (Print):_____ Immunizer 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 NAS	SQ IM NAS		
						LA RA	SQ IM		
						LA RA	SQ IM		
						LA RA	SQ IM		