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Section 8 Questions (1-7) Below pertain to all scences and with feel to determine your eligibility to be socialized to an even of monotorial to high feer? Pharmacist Verification of DUBs - 1755 NO 0 Does the person have a new or monotorial to high feer? YES NO 0 Does the person have a coupling have proteins, or open wound that prompted you to get a tetamis shot? YES NO 1 Does the person have a chirach have an end read have an end to an eligibility of the protein and the potential proteins? YES NO 1 Does the person have a chirach have an endition of long terms in mediating charms and person to be vaccinated work and another on endition of long terms in mediating charms and person to be vaccinated work and a secure value and work and another on endition of long terms in the person to be vaccinated work have a social endition of long terms and terms in proteins? YES NO 6 Is the person to be vaccinated work have a vaccinated			-	-					Meningococc	al Varicella	HPV	IPV
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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, Acterima, Cytoxan, Rituxan, adalimumab, infliximab or etamercept), high dose methotrexate, azathioprine, mercaptopurine, anticancer drugs, antivirals or radiation treatment, Crossan, Rituxan, adalimumab, infliximab or etamercept), high dose methotrexate, azathioprine, mercaptopurine, anticancer drugs, antivirals or nadiation treatment, Crossan, Rituxan, adalimumab, infliximab or etamercept), high dose methodrexate, azathioprine, mercaptopurine, anticancer drugs, antivirals or nadiation treatment, Crossan, Rituxan, adalimumab, infliximab or etamercept), high dose methodrexate, azathioprine, mercaptopurine, anticancer drugs, antivirals or nativirals or material or adjusted to blood or blood products, been given immune (gamma) globulin, or antivirals in the past ver? 11. Does the person to be vaccinated have a history of thrombocytopenia or thrombocytopenia purpura (MMR II only)? YES NO 12. Does the person to be vaccinated have a history of thrombocytopenia or thrombocytopenia purpura (MMR II only)? YES NO 13. Does the person to be vaccinated have a history of thrombocytopenia or thrombocytopenia purpura (MMR II only)? YES NO 14. Does the person to be vaccinated have a history of thrombocytopenia or thrombocytopenia purpura (MMR II only)? YES NO 15. Does the past human, as applicable, to administration for observation by the administration for have setted to receive. I acknowledge that I have have and administration for observation by the administration registry. Inderstand the provieif, my heirs, and personal representatives. J f	-	-						umps/rubella (ivi	WR II), sningles, a	answer questio		
Acternia, Cytoxan, Rituxan, adalimumab, influimab or etanercept), high dose methodrexate, azathioprine, mercaptopurine, anticancer drugs, antivirals or radiation treatment, critison or high-dose steroid therapy (prednisone >20mg/day or equivalent) for longer than two weeks? NO 11. Boes the person to be vaccinated received antibodies, a transfusion of blood products, been given immune (gamma) globulin, or antivirals in the past year? NO 11. Does the person to be vaccinated received antibodies, a transfusion of blood products, been given immune (gamma) globulin, or antivirals in the past year? NO 11. Does the person to be vaccinated new 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 argere. NO NO Inbreby give my consent to Wallmart, as applicable, to administer the medications(s) 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) like of the vaccine(s) in ave elected to receive. I acknowledge that have had a chance to ask questions and that such questions were answered to my satisfaction. I acknowledge that have been advised to remain near the vaccinetion location for approximately 15 minutes after administration of the vaccine(s) listed above. Initials: Inderstand the purposes/the medication may and all liabilities or claims whether known or unknow marising in any way related to the administration of the vaccine(s) listed above. Initials: Inderstand the tadministration of th								vira Enhral Cimzi	a Simnani Simna	ni Aria, Valianz	-	-
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 il only)? YES NO Section C Please read the section below carefully and sign and date acknowledging that you understand and argere. YES NO 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 vaccina(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 statifaction. I acknowledge that I have been advised to remain near the vaccinacito location for approximately IS minutes after 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, Imay prevent disclosure of my immunization to the state registry with a signed doc1. The Pharmacist has informed me that I may have the right to refuse. I acknowledge that edministration of this vaccine will be reported to any required local, state, or federal health authorities. Initials: I understand, 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	Actermra, Cytoxa	an, Rituxan, adalir	numab, infliximab	or etanercept), h	igh dose methotre	xate, azath	ioprine,				ation treati	ment,
11. Does the person to be vaccinated have a history of thrombocytopenia or thrombocytopenia purpura (MMR II only)? YES NO Section C Pieze read the section below carefully and sign and date acknowledging that you understand and agree. Increber give my consent to Walmart, as applicable, to administer the medications(1) have requested above. Indirecting the tracking healthcare provider. On behalf of myself, my heirs, and have received, read and/or had explained to me the Vaccine Information Statement and/or Vaccine Patient Fact Sheet for the vaccine(s) have elected to receive. I acknowledge that I have head 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 vaccine(s) I bimutes affer 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: understand, acknowledge, and consent that the administration of this vaccine will be administration registry. Understand the purposes/benefits of my state's immunization registry and acknowledge that, depending upon my state aw, 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 understand the gale pathemacy. I consent to the release of medical information when necessary for billing, reimbursement, and med				S: 7 1	, ,			given immune (g	amma) globulin, (or antivirals in th	-	-
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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, 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: Patient/Legal Guardian Name:Signature:Date: Pharmacist Name (Print): Pharmacist Name (Print): Administering Individual Name and Title (Print): Yaccine Lot # Exp. Date Manufacturer NDC Dosage Site Route VIS Date RPh Initials Vaccine Lot # Exp. Date Manufacturer NDC Losage Site Route VIS Date RPh Initials LA RA NAS SQ IM NAS LA RA NAS SQ IM NAS LA RA SQ IM	reported to any	required local, sta	te, or federal hea	Ith authorities. In	itials:							
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Immunization Insurance Coverage Form

Date:						
Patient Name (First & Last):	Phone Number:					
Section A: Insurance Coverage Information Please provide <u>all applicable</u> insurance information have no active insurance coverage, skip section A of	below. FOR COVID-19 IMMUNIZATIONS ONLY: If you					
Note: For active insurance coverage, but unsure of y Social Security Number. (Last 4 digits of SSN)	our insurance information, provide the last 4 digits of your					
1 Pharmacy Insurance Information:						
Insurance Carrier:	Patient ID:					
Primary Cardholder (Y/N):	Dependent Number:					
BIN: PCN:	Group:					
2 Medical Insurance Information:						
Insurance Carrier:	Patient ID:					
Group:	Payer ID:					
3 Medicare Insurance Information (RED, W	'HITE & BLUE CARD):					
Name (as it appears on the card):						
Medicare ID #:						

Section B: COVID-19 Immunization No Insurance Coverage Attestation

FOR COVID-19 IMMUNIZATIONS ONLY: Complete the section below ONLY if you are receiving a COVID-19 immunization AND do not have active insurance coverage.

The Federal government wants to make sure that all individuals can receive the COVID-19 Vaccine regardless of health insurance status. Walmart is participating in the federal government's COVID-19 Uninsured Program. If you do not have insurance, we are asking you to confirm this fact to ensure we correctly file the claim for your vaccination service. We will need one of the below forms of identification.

Driver's License Number: _

State Issued ID: ____

- I hereby declare that I do not have insurance coverage of any kind including, but not limited to Commercial Insurance, Medicare, or Medicaid.
- I understand that my lack of insurance does not prevent me from receiving the COVID-19 Vaccine.
- I understand that I will not be charged for the vaccine administration.
- I agree to inform my pharmacists if I am enrolled in Medicaid within the next 30 days.

Patient Signature

