Image:         Image:<	Walmart and	Sam's Club	/accine Admir	nistration Reco	ord and Inforr	ned Con	sent		Walmart 🔀	Sams		
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Op voju hurve a Primary Care Physician?       IND       Primary Care Physician?       IND       Street Rame:         Op voju authorize this parmacy to send your information to your Primary Care Physician?       IND       IND       Mega Menjagooccal       Variaelia       1PV       IPV       IP								,				
by our authorize this pharmacy to send your information to your Primary Care Physician?       IN IM       IFPA       Meningeoted:       Variation       IPV       IPV         Sector Requested:       F.Y.       COVID-19       Perunacity Verification of 20015       IPV       IP						me:			Street Nam	ie:		
Vaccine Requested:         Function         Strington         Table         Title         MAIL         Bits A         Head         Memory and transmission         Memory and trans												
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
a. Does the person have a new or moderate to high fever?         YES         NO           b. Does the person have a coupling?         YES         NO           c. Does the person have a coupling?         YES         NO           c. Does the person have a coupling?         YES         NO           c. Does the person been worning?         YES         NO           Does the person be vaccinated ence a chranic health tracking.         YES         NO           Description to be vaccinated ence a chranic health tracking.         YES         NO           Paramackin there are the person be vaccinated ence or neeking watches outdide of a medicate.         NO and the person be vaccinated have a search ence or neeking watches outdide of a medicate.         NO and the person be vaccinated have a search ence on the person be vaccinated have a search ence on the person be vaccinated have a search ence on the person be vaccinated have a search ence on the person be vaccinated have a search ence on the person be vaccinated have a search ence on the person be vaccinated have a search ence on the person be vaccinated have person be vaccinated have a search ence on	•				•			<u> </u>				
b.       Does the jerson have a cough?       YES       NO         c.       Date the parson have a longible, or open wound that prompted you toget a tetawars shot?       YES       NO         c.       Description of the vaccinated have alregible to medications, food components, vaccine components, or take? If yes, please list.       YES       NO         2.       Description of the vaccinated have alregible to medications, food components, vaccine components, or take? If yes, please list.       YES       NO         3.       Description of the vaccinated have alregible to medications, food components, vaccine control, of the No all documents canceles.       YES       NO         2.       Description of the vaccinated have alregible control of long term health proceeding?       YES       NO         3.       Description of the vaccinated over had a reaction, lainted, or fell duay after receiving a vaccine or obta any physician or othe healthcare professional were caultoned over working approxim, the next month, or breast-feeding?       YES       NO         3.       Description of the vaccinated currently pregonant, considering person to be vaccinated currently pregonant, considering person how alregible person to be vaccinated currently pregonant, considering person howe alregible person to be vaccinated currently pregonant, considering person howe alregible person how alregible person vaccinated mean system, isin contact with anyone with a severely warkened immune system of source is a non-precision and the next month, or breast-feeding?       YES       NO         6. <td>1. Is the person t</td> <td>o be vaccinated s</td> <td>ick or injured toda</td> <td>y? If Yes,</td> <td>· · · · ·</td> <td></td> <td>,</td> <td>,</td> <td></td> <td></td> <td></td> <td></td>	1. Is the person t	o be vaccinated s	ick or injured toda	y? If Yes,	· · · · ·		,	,				
a.       Hist the person beam committing?       YES       NO         2.       Does the person be watched the devisions, food components, variable components, or lates? If yes, please list.       YES       NO         2.       Does the person to be variable to the variable variable to the variable variable to the variable variable variable to the v				erate to high feve	r?							
e.         by you have a cut, hjury, purkture, or open wound has prompted you to get a tetanus sha?         VES         NO           2. Does the person to be vaccinated have allergies to medications, food components, vaccine components, or late? If yes, please list.         VES         NO           3. Does the person to be vaccinated have a larging is to medications, powral, neconyco, phenol, access, thimmessol         VES         NO           4. Has the person to be vaccinated have a chronic health condition or long-term health proliem?         VES         NO           5. One the person to be vaccinated have a chronic health condition or long-term health proliem?         VES         NO           6. Is the person to be vaccinated have a chronic health condition or long-term health proliem?         VES         NO           6. Is the person to be vaccinated have have a vackened maximum vaccines or treat working on watered vanawade vackened manue system. Bin conditi with synoper weakened immune system bin increative thi anyone with a sweret? weakened immune system. Bin conditive this synoper weakened immune system bin increative this anyone weakened immune system. Bin conditive this synoper weakened maximum system bin increative this anyone weakened manue system. Bin conditive this synoper weakened maximum system bin since weakened manue system. Bin conditive this synoper weakened manue system bin conditive. The synoper maximum electronic system the system than one system bin conditive. The synoper maximum system bin since weakened manue system bin conditive. NO           6. Is the person to be vaccinated any vaccinated and second peradive reqavalane dimune system. Bin conditive this synoper maximu												
2. Does the person to be vaccinated have allergies to medications, food components, vaccine components, or lates? If yes, please list.       YES       NO         3. Does the person to be vaccinated have a chronic health condition or long-term health problem?       YES       NO         4. Note the person to be vaccinated have a chronic health condition or long-term health problem?       Note the person to be vaccinated have a chronic health condition or long-term health problem?       Note the person to be vaccinated have a chronic health condition or long-term health problem?       Note the person to be vaccinated have a chronic health condition or long-term health problem?       Note the person to be vaccinated new rends ascure disorder for which they are on seizure medications, a brain disorder, Guillain-Barre Syndrome, or other nervous sptem problem?       No         5. 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 new aveakened immune system disorder / Border immune system disorder?       YES       NO         8. Is the person to be vaccinated currently or home infusions, weakly injections (such as femicate)       YES       NO         9. So the person to be vaccinated new aveakened immune system disorder / Border immune system disorder?       YES       NO         9. To be store information of the person will be considered in the part of the person will be considered in the part wascing as the person to be vaccinated nerverive avaccinated intervive andinterim prelevive avaccinated nerverive avaccinated intervive andi				r open wound that	prompted you to	get a tetan	us shot?	?				
Example: cgg, boine protein, gettar, gettarnish, polympin, neorgica, phenol, yeast, thimeroad       YES       NO         2. Does the person to be vaccinated area charonic handling or logg area metably ordinated area charonic handling or logg area charonic disorders, murdpace is the protein a marker?       YES       NO         2. Hist the person to be vaccinated even had a section, tanding ther receiving a vaccines coll scheder area marker?       YES       NO         5. Is the person to be vaccinated currently pregnant, considering becoming pregnant in the next month, or breast-feeding?       YES       NO         6. Is the person to be vaccinated as enable and indicated area the person or be vaccinated as the person or be vaccinated as the person will be eracely indicated area the person or be vaccinated as the person or be vaccinated as the person will be receiving COVID-19, varietal, measter/murps/rubella (MMI til), shingles, answer questions (311) below: any adver immune system disorder, a varia disorder, future and the person will be eracely person will be receiving covid the person will be accinated currently on home influions, weekly injections (such as temicade, Humina, Inbred, Cirrati, Simponi, Aria, Yeljan, Crencia, Aria, a rank and Rituan, althouse,						-						
Examples: heart, lung. Lidney, neuronacular, key, metabolat diseases, anthma, alabites, neurola, other blood disorders, enclosed and ever call one of a ward wore about receiving variation access or receiving variations or used in a variation or base variation and the variation of the variatis the variatis of receiving the variation of the variation of the									s, please list.		YES	NO
4. Has the person to be vaccinated ever had a reaction, fainted, or fet dizy after receiving a vaccine or has any physician or other healthcare professional ever cautioned variande you about receiving carcines outputies of a medical setting?  5. His the person to be vaccinated ever had a seture disorder for which they are on seizure medications, a brain disorder, Guillain Barre Syndrome, or other nervous system problems?  7. Does the person to be vaccinated eurently pregnant, considering becoming pregnant in the next month, or breast-feeding? 7. Obset the person to be vaccinated as a wakened immune system, is in contact with aryone with a severely weakened immune system or in long-term treatment with diags such as high-does steroid? 7. The persons in North Carolina, OB if the person will be receiving COVID-19, varicella, measles/mumps/rubella [MMR II], shingles, answer questions (61:1) below. 8. Has the person to be vaccinated neceved any vaccinations or skin tests in the past four weeks? 7. No 7. Does the person to be vaccinated received any vaccinations or skin tests in the past four weeks? 7. No 7. Bis the person to be vaccinated received any vaccinations or skin tests in the past four weeks? 7. No 7. In bus the person to be vaccinated received any vaccination or blood or blood products, been given immune (gamma) globulin, or antivirals in the past yer? 7. No 7. In bus the person to be vaccinated neceved antibodies, a transfusion of blood or blood products, been given immune (gamma) globulin, or antivirals in the past yer? 7. NO 7. In bus the person to be vaccinated new abstrary of thrombocrytopenia purpure (MMR II only)? 7. VES NO 7. No 7. In bus the person to be vaccinated new abstrary of thrombocrytopenia purpure (MMR II only)? 7. VES NO 7. In bus the person to be vaccinated new abstrary of thrombocrytopenia purpure (MMR II only)? 7. VES NO 7. In bus the person to be vaccinated new abstrary of thrombocrytopenia purpure (MMR II only)? 7. VES NO 7. In bus the person to be vaccinated new abstrary of thrombo											YES	NO
or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?         VES         NO           5. Is the person to be vaccinated eventad a seizure disorder for which they are on seizure medications, a brain disorder, Guillain-Barre Syndrome, or other nervous system problems?         VES         NO           6. Is the person to be vaccinated currently pregnant, considering pregnant in the next month, or breast-feeding?         VES         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-does storols? <i>Examples: concer, lexiemia, lymphona, HIV/AIDS, transplant, theunatoid arthrits, ank/solarg spond/kills, Charly Secser aran other immune system for othe Vaccinated events?         NO           8. Is the person to be vaccinated currently on home infusions, weakly injections (such as Remicade, Humira, Enbrel, Cinala, Simponi, Aria, Xeljanz, Orencia, Arava, Acternar, Oytowan, Rituwan, adalimumab, influxinad bre clametorpil, ligh doe methorizate, atahloprine, mecaptopuline, anitoacer drugs, antivirals or radiation or listor of the buod products, been given immune (gamma) globulin, or antivirals in the past ver?         NO           10. These the person to be vaccinated erceived any vaccination or skill and order due vaccinated advalanted to the vaccinated baye and into or vaccination or abiod products, been given immune (gamma) globulin, or antivirals in the past ver?         NO           11. Does the person to be vaccinated advalanted to the doministration of the vaccines of the vaccines of the vaccines of the vaccines of the vaccinated have a history of thrombocytopenia or thrombocy</i>					· · · · · ·				· · ·			
S. Has the person to be vaccinated ever had a seizure disorder for which they are on seizure medications, a brain disorder, Gullain-Barre Syndrome, or other nervous system, for home problems?         NO           6. Is the person to be vaccinated currently pregnant, considering becoming pregnant in the next month, or breast-feeding?         VES         NO           7. Does the person to be vaccinated have a weakened immune system (in it is anyone with a severely weakened immune system or in long-term treatment with drags such as high-does stroids?         VES         NO           8. Has the person to be vaccinated crecived any vaccinations or skin tests in the past four weeks?         VES         NO           9. Is the person to be vaccinated received any vaccinations or skin tests in the past four weeks?         VES         NO           10. Is sthe person to be vaccinated received any vaccinations or skin tests in the past four weeks?         VES         NO           9. Is the person to be vaccinated received any vaccinations or skin tests in the past four weeks?         VES         NO           10. Is sthe person to be vaccinated received any vaccinations or skin tests in the past four weeks?         VES         NO           11. Does the person to be vaccinated nervel (predinose - 20m/day or equivalent) for longer than two weeks?         VES         NO           11. Does the person to be vaccinated nave a history of thrombocytopenia or thrombocytopenia purpura (MMRI in ohy)?         VES         NO           11. Does the person to be vaccinated wee a history of thr								has any physician	or other healthc	are professional		
problems?         YES         NO           6. Is the person to be vaccinated over a weakened immune system is in contact with anyone with a severely weakened immune system disord         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 disord         YES         NO           6. Is the person to be vaccinated created any vaccinations or skin tests in the past four weeks?         YES         NO           7. Is the person to be vaccinated received any vaccinations or skin tests in the past four weeks?         YES         NO           8. Is the person to be vaccinated received any vaccinations or skin tests in the past four weeks?         YES         NO           10. Is the person to be vaccinated received any vaccinations, weekly injections (such as Remicade, Humina, Enberl, Cinzia, Simponi, Simponi Aria, Relfanz, Cinercia, Arava, Actermar, Cytoxan, Rituan, adalimumab, infiliximab or etamercept), high dose methotreate, arathogine, mecraptoprine, anticancer drugs, antivirals or radiation treatment, cytoxan, Rituan, adalimumab, infiliximab or etamercept), high dose methotreate, arathogine drug etamine grane drug etamine that weekend are created sector be avaccinated new carefully and gran of drug carefully conversity on a gran of drug exclusion or blood or blood products, been given immune (gamma) globulin, or antivirals in the past year?           11. Does the person to be vaccinated new callify and gran of drug carefully conversity on and gran of drug carefully conversity on a drug carefully gran drug carefully gran drug carefully gran drug carefuly grug gran drug carefully grug gran drug carefuly grug		v					0	, a brain disorder,	. Guillain-Barre Syr	ndrome, or othe		
2. 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-does stroids." Examples cancer, leukenin, lymphone, HM/JDS, transplant, heumatoid arthritis, and/subing goodytike, Grahn's discour or any other immune system discourses (1-11) below.       NO         For persons in North Carolina, <u>OB</u> if the person will be receiving COVID-19, varicella, measles/mumps/rubella (MMRII), shingles, answer questions (1-11) below.       NO         8. Is the person to be vaccinated currently on home infusions, weekly injections (such as Remicade, Humira, Enbrei, Cimzia, Simponi, Aria, Xeljanz, Orencia, Arava, Actermia, Cytoxan, Rituxan, adalimumab, Infulninab or etanercept), high doe methodreaxee, zashiporine, anticancer drug, antiviasi or radiation treatment, actions on high-does stroid therapy (redshions ->>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>					,				,	,		•
drugs such as high-does steroids?       Examples cancer, leukemia, lymphama, HW/AIDS, transplant, rheumatoid arthritis, ankylasing spondylitis, Crohn's disease or any other immune system disorder?       NO         For persons in North Carolina, QB, if the person will be receiving COVID-19, varicella, measles/mumps/rubella (MMR II), shingles, answer questions (B-11) below.       NO         8. Has the person to be vaccinated received any vaccinations or skin tests in the past four weeks?       NO         9. Is the person to be vaccinated received any vaccinations or skin tests in the past four weeks?       NO         10. Bas the person to be vaccinated received any vaccinations or skin tests in the past four weeks?       NO         11. Does the person to be vaccinated neceived antibodies, a transfusion of blood or blood products, been given immune (gama) globulin, or antivirals in the past year?       YES       NO         11. Does the person to be vaccinated neceived antibodies, a transfusion of blood or blood products, been given immune (gama) globulin, or antivirals in the past year?       YES       NO         11. Does the person to be vaccinated neceived antibodies, a transfusion of blood or blood products, been given immune (gama) globulin, or antivirals or neceiving this medication and have conserved to magnet the medications(3) have requested above. Lunderstand the benefits and risks of receiving this medication and have conserved to magnet.       NO         11. Does the person to be vaccinated due and sing and magnet question server associated massociated magnet and and gree and/or had explained to me the Vaccine Information Statement and/or Vaccine Patient and the administr	6. Is the person	o be vaccinated o	urrently pregnant	t, considering bec	oming pregnant i	in the next	month	ı, or breast-feedir	ıg?		YES	NO
YES       NO         For persons in North Carolina. QB 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 received any vaccinations (such as Remicade, Humira, Enbrid, Cimzia, Simponi, Simponi Aria, Xeljanz, Orencia, Arava, Actermia, Cytoxan, Rusun, adalimumab, infliximab or etanercept), high dose methodrexate, azahloprine, mercaptopurine, anticancer drugs, antivirals or radiation treatment, originate on the vaccinated received antibodies, a transfusion of blood or blood products, been given immune (gamma) globulin, or antivirals in the past year?         10. Has the person to be vaccinated have a history of thrombocytopenia or thrombocytopenia purpura (MMR II) with the person or be vaccinated have a history of thrombocytopenia or thrombocytopenia purpura (MMR III) with the person or be vaccinated balve achived antibadies, a transfusion of blood or blood products, been given immune (gamma) globulin, or antivirals in the past year?         VES       NO         Sector C. Places read the section below accilully and sign and date achowided gint thay ou anderstand 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 Hast Hast Administeria administration or observation by the administeria fush the past lever. In aaknowideg that I have had a chance to as (upaceive Wulllant); I staff, agents, s	7. Does the pers	on to be vaccinate	ed have a weaken	ed immune syster	n, is in contact wi	th anyone	with a s	severely weakene	ed immune system	n or in long-term	treatment	with
For persons in North Carolina, OB 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?       VES       NO         9. Is the person to be vaccinated received any vaccinations or skin tests in the past four weeks?       VES       NO         9. Is the person to be vaccinated received any vaccinations or skin tests in the past four weeks?       VES       NO         10. Has the person to be vaccinated received antibodies, a transfusion of blood products, been given immune (gamma) globulin, or antivirals in the past ver?       NO         11. Does the person to be vaccinated neareight, bigh does methody and and date acknowledging that you understand and agree.       NO         11. Does the person to be vaccinated income table of the medications (b) have requested above. Linderstand 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 frast Sheet for the vaccine(s) have elected to receive. I acknowledge that 1 have been advised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administration registry and adminestration registry wind asign and we releave of the querice (sign the same presentatives). If uily release and discharge Walmart, its staff, agents, successor, division, affiliates, officers, directors, contractors, and employees from any and all liabilities or insw whether known or unknown were released to the vaccine(s) liabilities or instructive kind walknowinge that administration of the vaccine(s) liabilities or				leukemia, lympho	ma, HIV/AIDS, trai	nsplant, rhe	eumato	id arthritis, ankyld	osing spondylitis, C	Crohn's disease	VEC	NO
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, Actermac, Orkona, Rituxan, additummab, infikumab, or tatareceived, high dose methorexate, asathiorized received rulation 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         11. Does the person to Walmart, as applicable, to administer the medications(s) ih have requested above: understand the benefits and risks of receiving this medication and have received, recad nuck, recad nuck equively 15 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, and employees from any and all ilabilities or discharge methode, and consent that the administration of this vaccine will be entered into my state's immunization to the state registry with a signed Opt-Out. The Pharmacist has informed me that tima yhave the right to refuse. Lacknowledge that the administration of this vaccine will be reported to any required local, state, or federal health authorizies.         Inderstand, acknowle		•									-	-
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	-	-
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(\$) 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(\$) 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 15 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(\$) 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 gurposes/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-Cu. 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, adubticed insurance benefits due to me to be paid to the pharmacy. I consent to the release of medical information when necessary for billing, reinbursement, and medical protocol. Initials:	11. Describer of			- <b>C</b> ( <b>b</b> - <b>c</b> - <b>b</b> - <b>c</b> - <b>b</b> - <b>c</b> - <b>b</b> - <b>c</b>				(1 41 40 111 )2				
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 head a chance to ask questions and that such questions were answered to my satisfaction. I acknowledge that I have head noised to remain near the vaccination location for approximately 15 minutes after administration for observation by the administrating 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 on claims whether known or unknown arising in any way related to the administration of 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 am aware a pharmacist, qualified pharmacy technician or state authrized 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 authrized pharmacy intern, as allowed by law, might be administering this medication. Initials:         I am aware a pharmacist, qualified pharmacy technician or state authorized pharmacy to rubu location. Refusing to initial and acknowle			,			<u>, , ,</u>	· ·				YES	NO
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 15 minutes after administration for observation by the administrating 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 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:         I am aware a pharmacist, qualified pharmacy technician or state authorized pharmacy intern, as allowed by law, might be administering thealth autor insucceon my treatment. Initials: <tr< td=""><td></td><td></td><td></td><td>5</td><td>5 5</td><td>,</td><td></td><td>5</td><td>nd the benefits an</td><td>d risks of receivi</td><td>ng this med</td><td>dication</td></tr<>				5	5 5	,		5	nd the benefits an	d risks of receivi	ng this med	dication
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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. I understand the administration of this vaccine will be entered into 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:         I am aware a pharmacist, qualified pharmacy technician or state authorized pharmacy intern, as allowed by law, might be administering this medication. Initials:         I and aware.       Signature:       Date:         I administering Individual Name and Title (Print):       Signature:       Date:         Administering Individual Name and Title (Print):       NDC       Dosage       Site       Route       VIS Date       RPh Init												
all liabilities or claims whether known or unknown arising in any way related to the administration of the vaccine(s) listed above. Initials:         1 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 deadministration of this vaccine will be reported to any required local, state, or federal health authorities. Initials:         1 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:         1 am aware a pharmacist, qualified pharmacy technician or state authorized pharmacy intern, as allowed by law, might be administering this medication. Initials:         Patient/Legal Guardian Name:												
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:												
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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:		0							<b>U</b> ,		to the state	е
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:	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											
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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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:Date:	I am aware a pha	armacist, qualified	pharmacy techn	ician or state auth	orized pharmacy	intern, as	allowed	d by law, might be	e administering th	is medication. I	nitials:	
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:Date:	By initialing here	. I acknowledge r	eceipt of Walmart	:/Sam's Club Heal	h & Wellness No	tices. Lund	erstand	d that the Notice	is subject to chan	ge, and I can oht	ain a curre	nt
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:       Pharmacist Signature:         Administering Individual Name and Title (Print):        Pharmacist Signature:       Administration Date/Date VIS Given:         Vaccine       Lot #       Exp. Date       Manufacturer       NDC       Dosage       Site       Route       VIS Date       RPh Initials         Image: Site in the intermediate intermedi												
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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					
<b>1</b> 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:					
<b>3</b> 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

