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

Peter Kelly 1 Cooper Plaza Camden NJ, 08103 | Manual Reporting Initials: | Date: | Time:

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: _____

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? ☐ 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 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. *Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast, thimerosal*	YES	NO
3. Does the person to be vaccinated have a chronic health condition or long-term health problem? *Examples: heart, lung, kidney, neuromuscular, liver, metabolic diseases, asthma, diabetes, anemia, other blood disorders, neurologic or is the patient a smoker?*	YES	NO
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, 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 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 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(s) listed above. **Initials:** X

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:** X

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:** X

I am aware a pharmacist, qualified pharmacy technician or state authorized pharmacy intern, as allowed by law, might be administering this medication. **Initials:** X

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:** X

Patient/Legal Guardian Name: X _____ **Signature:** X _____ **Date:** X _____

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
Janssen	206A21A	06/23/21	J&J	59676-0580-15	0.5ML	LA RA NAS	SQ IM NAS	03/19/21	
						LA RA	SQ IM		
						LA RA	SQ IM		
						LA RA	SQ IM		

ATTESTATION OF INSURANCE COVERAGE

Pharmacy Note:

The following form is a required document for a mobile COVID-19 vaccine clinic that cannot processes immunizations utilizing the Clinical Services App.

Date: _____

Patient Name (First & Last): _____ Phone Number: _____

Section A: Insurance Coverage

Please provide **all applicable** insurance information below. If you have no active insurance coverage, skip section A and complete section B below.

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, WHITE & BLUE CARD):***

Name (as it appears on the card): _____

Medicare ID #: _____

Section B: No Insurance Coverage

Complete the section below ONLY if you 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

Eligibility Attestation

Date: _____

First Name: _____ Last Name: _____

DOB: _____

Please fill out this form to confirm your eligibility to receive a COVID-19 vaccination.

- ☐ Healthcare personnel
- ☐ Age Based Eligibility
  - ☐ 75+
  - ☐ 70-74
  - ☐ 65-69
  - ☐ 60-64
  - ☐ 55-59
  - ☐ 50-54
- ☐ 16-64 years of age with medical conditions
- ☐ Essential worker:
  - ☐ manufacturing workers
  - ☐ first responders (e.g., police and firefighters)
  - ☐ corrections officers
  - ☐ food and agricultural workers
  - ☐ U.S. Postal Service workers
  - ☐ grocery store workers
  - ☐ public transit workers
  - ☐ education sector (teachers, support staff, and child care workers)
- ☐ Essential Worker: transportation, logistics, food service, construction, finance, legal, information technology, communication, media, public safety (engineers), water and wastewater and energy sectors.
- ☐ Other state defined eligible category (age, occupation, etc.):
  - ☐ (please list)_____
- ☐ Eligible per Waste Avoidance Protocol

I hereby confirm that to the best of my knowledge and belief I belong to the priority group that I selected above and that I am currently eligible to receive a COVID-19 vaccine.

Signature: _____

For associate use only at Mobile Clinics:
List the relevant ID or documentation shown.

_____

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