Pharmacist Verification

Standing Order: Automated Reporting unless documented below.

- Manual Reporting (Twinrix, Prescription)

Initials/Date/Time _____

Walmart Sam's Club

1901d

Race / Ethnicity
- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ Hispanic or Latino
- ☐ Native American or Alaska Native
- ☐ Native Hawaiian or Pacific Islander
- ☐ Decline to State

Gender
- ☐ Male
- ☐ Female

Mother's Maiden Name: _____

Patient Health Questionnaire, Consent Form, and VAR

Section A Please Print Clearly

Name ☐

Last Name | First Name | MI | Date of Birth | Age

Medicare/Ins ID # | Rx Group # | Bin #

DOB ☐

Home Address | City | State | ZIP | Phone #

Primary Care Physician | Physician Address | Physician Phone #

Are you covered by Medicaid? (circle): Yes No **Are you covered by Medicare Part B or D? (circle): Yes No**

Vaccine Requested (circle): Flu Pneumonia Shingles Tdap Td MMR Hep A Hep B HPV Meningococcal Varicella Other _____

DUR ☐

Section B *The following question will help us determine your eligibility to be vaccinated today*	Yes	No
1. Is the person to be vaccinated feeling sick today or do they have a moderate to high fever? **RPH Initials:**		
2. Does the person to be vaccinated have allergies to medications, food, vaccine components or latex? (Examples: eggs, bovine protein, gelatin, gentamicin, polymyxin, neomycin, phenol, yeast or thimerosal)		
3. Has the person to be vaccinated received any vaccination or skin tests in the past four weeks? If yes, please list the vaccination:		
4. Has the person to be vaccinated ever had a serious reaction to an influenza vaccine or any other vaccine?		
5. Has the person to be vaccinated ever had a seizure disorder, brain disorder, or Guillain-Barre Syndrome?		
6. Is the person to be vaccinated pregnant or considering becoming pregnant in the next month?		
7. Is the person to be vaccinated 65 years of age or older?		
8. Is the person to be vaccinated a smoker?		
9. Does the person to be vaccinated have a chronic condition or long term health problem such as, heart disease, lung disease, asthma, kidney disease, diabetes, anemia, or other blood disorders?		
10. If a person answers YES to question # 7, 8, or 9, have you ever had a pneumonia vaccination?		
11. Has the person to be vaccinated ever had a shingles vaccination (patients 60 years of age and older)?		
12. Is the person to be vaccinated currently on home infusions, weekly injections, steroid therapy, anticancer drugs or radiation treatment?		
13. Does the person to be vaccinated have cancer, leukemia, lymphoma, HIV/AIDS or any other immune system disorder or are you in contact with anyone who has a severely weakened immune system?		
14. Has the person to be vaccinated received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug during the past year?		
IF A PERSON ANSWERS YES TO ANY QUESTION, THEY MUST TALK TO PHARMACIST BEFORE BEING VACCINATED		

Section C Consent and Waiver: *Please read each section carefully and initial in the corresponding box 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 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.

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 _____

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

Section D *The following section is to be completed by* ***health care provider only.***

Immunizing Pharmacist Name (Print) _____ **Immunizing Pharmacist Signature** _____

Intern Name (Print) _____ **Administration Date/Date VIS Given:** _____

Vaccine	Lot#	Exp. Date	Manufacturer	NDC	Dosage	Site (LA/RA)	Route (IM/SQ)	VIS Date	RPh Initials
						LA RA	IM / SQ		
						LA RA	IM / SQ		
						LA RA	IM / SQ		
						LN RN	Nasal		

Authorizing Physician: Address of Authorizing Physician:

Phone : Fax :

EXHIBIT A
RELEASE OF LIABILITY FORM

EACH MEMBER REQUESTING IMMUNIZATION SERVICES **AT ORGANIZATION'S LOCATION** IS REQUIRED TO COMPLETE, SIGN, AND SUBMIT THIS FORM TO THE ATTENDING TECHNICICAN PRIOR TO RECEIVING IMMUNIZATION SERVICES

I, the undersigned, am requesting Immunization Services be provided by Wal-Mart Stores, Inc. ("**Provider**"), which shall be sponsored by [Sequim School District] ("**Organization**"). I release Organization and Provider, their agents and Members, and agree to hold them harmless from any and all liability, claims, damages, actions and causes of action whatsoever, for loss, damages, or injury to persons or property, regardless of when they occurred and however caused with which Organization and Provider and their agents or Members may be charged in connection, directly or indirectly with the Immunization Services.

I further agree to disclose in writing below, all of my physical and medical conditions, limitations and sensitivities, and agree to release and hold Organization and Provider and their agents and Members harmless from any liability, claims, damages, actions and causes of action in any way relating to or arising from said conditions, limitations or sensitivities.

I expressly agree that all parts of the Immunization Services process will be undertaken at my own risk, and I represent that I fully understand any risks involved, and that I am able to participate in all Immunization Services provided to me.

I further agree that Organization and Provider and their agents and Members shall not be liable for any claims, demands, injuries, damages, actions, or causes of action whatsoever arising out of, or connected with the use of any of their services, facilities or equipment.

Signed:

Signature:_____ Date:_____

Printed Name: _____

Please list all conditions, limitations or sensitivities: _____

_____

Please list any conditions for which you have has seen a physician in the past year: _____

_____

Please list any concerns that you feel the pharmacist should know about:_____

_____

_____