Walmart Pharmacy

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 St. Luke's Episcopal School ("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: _____ 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:_____

_____

Insurance Bin# (or RxBin):_____Group# (or RxGrp):_____

Member ID (or Contract #):_____

Relationship to Cardholder: Self ____Spouse____Child___Cardholder Name:_____