Massachusetts Immunization Information System

# Vaccine Administration Record

Patient: JEFFREY RIEL Birth Date: 04/30/1983 Gender: Male

Address: 745 WESTFORD ST, LOWELL, MA, 01851

| Vaccine Group | Vaccine | Date Given mo/day/yr | Dose | Route(PO, SC, IM, ID, IN) | Site(RA, LA, RT, LT) | Vaccine Lot# | Vaccine mfr. | Date on VIS | Date VIS Given | Admin By(Full name /Initials) | Title |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Hepatitis B | HepB Adult | 07/29/2015 | 1 | IM | LA | 4T4GJ | GlaxoSmithKline | 02/02/2012 | 07/29/2015 | MELANIE MARTIN | |
| | HepB Adult | 01/15/2019 | 1 | IM | LA | 5YY7T | GlaxoSmithKline | 07/20/2016 | 01/15/2019 | AMANDA RUGGIERO | |
| Diphtheria Tetanus Pertussis | | | | | | | | | | | |
| Tetanus Diphtheria Acellular Pertussis | | | | | | | | | | | |
| Tetanus Diphtheria | | | | | | | | | | | |
| Hib | | | | | | | | | | | |
| Poliomyelitis | | | | | | | | | | | |
| Pneumococcal Conjugate | | | | | | | | | | | |
| Hepatitis A | | | | | | | | | | | |
| Rotavirus | | | | | | | | | | | |
| Measles Mumps Rubella | | | | | | | | | | | |
| Meningococcal-Conjugate | | | | | | | | | | | |

*This report was printed by Carol Moriarty at Lowell Health Department from the MIIS on April 23, 2019 at 12:38 PM.*

Jeffrey Riel DOB: 4/20/83

**SECTION D** **HEALTHCARE PROVIDER ONLY**

**Complete BEFORE vaccine administration**

1. I have reviewed the **Patient Information** and **Screening Questions.** Initial here: AB
2. I have verified that this is the **vaccine requested** by the patient. Initial here: AB
3. This vaccine is appropriate for this patient based on the **Age Guidelines** provided by federal and/or state regulations and company policies. Initial here: _____

   3a. Does this patient have a high-risk medical condition? ☐ Yes ☐ No

   If yes, please list medical condition(s): _____
4. The **Vaccine NDC matches** the NDC on the bottom of this VAR form and the NDC on the patient leaflet. (Perform **3-way NDC match.**) Initial here: AB
5. I have verified the **Expiration Date** is greater than today's date and have entered the **Lot # and Expiration Date** in the field below. Initial here: AB

**For Shingrix®, Zostavax®, MMR® II, Varivax®, YF-Vax®, Menveo®, Imovax® and RabAvert®, ensure the vaccine is reconstituted following the package insert's instructions.**

Lot #: 12394R Expiration Date: 9/14/21

**For vaccines that have a diluent, complete the following:**

Lot #: _____ Expiration Date: _____

**SECTION E**

**Complete DURING the patient interaction**

1. I have asked the patient to confirm their **Name, DOB and Requested Vaccine** and verified it matches the information on the VAR form. Initial here: _____
2. I have reviewed the **Screening Questions** with the patient. Initial here: _____
3. I have reviewed the **VIS** with the patient. Initial here: _____

**SECTION F**

**Complete AFTER vaccine administration**

| Vaccine | NDC | Manufacturer | Dosage | Site of administration | VIS published date |
|---|---|---|---|---|---|
| ENGERIX-B 20MCG/ML INJ, 1ML (ADULT) | 58160-0821-11 | GLAXO SMITH KLINE | 1.000 ML | left | |

**Clinician's name (print):** Amaak **Clinician's signature:** [signature] **Title:** Pharmacist

**If applicable, intern name (print):** _____ **Administration date:** 04/6/19 **Date VIS given to patient:** 4/6/19

**Vaccine Reference Chart**

| Vaccine | Route | Dosage |
|---|---|---|
| Influenza | Intramuscular | 0.5 mL |
| Influenza (intradermal) | Intradermal | 0.1 mL |
| Influenza (nasal) | Intranasal | 0.1 mL each nostril |
| Hepatitis A | Intramuscular | 0.5 mL: Adolescents ≤ 18 years<br>1 mL: Adults ≥19 years |
| Hepatitis B | Intramuscular | 0.5 mL: Adolescents ≤ 19 years<br>1 mL: Adults ≥20 years |
| Hepatitis B (Heplisav-B) | Intramuscular | 0.5 mL |
| Hepatitis A/B (Twinrix) | Intramuscular | 1 mL: Adults ≥18 years |
| Human papillomavirus | Intramuscular | 0.5 mL |
| Japanese encephalitis | Intramuscular | 0.5 mL |
| Meningococcal ACYW-135 | Intramuscular | 0.5 mL |
| Meningococcal B | Intramuscular | 0.5 mL |
| MMR (measles, mumps, rubella) | Subcutaneous | 0.5 mL |
| Pneumococcal (Prevnar 13) | Intramuscular | 0.5 mL |
| Pneumococcal (Pneumovax 23) | Intramuscular or subcutaneous | 0.5 mL |
| Polio | Intramuscular or subcutaneous | 0.5 mL |
| Rabies | Intramuscular | 1 mL |
| Shingles/herpes zoster (Zostavax) | Subcutaneous | 0.65 mL |
| Shingles/herpes zoster (Shingrix) | Intramuscular | 0.5 mL |
| Td (tetanus and diphtheria) | Intramuscular | 0.5 mL |
| Tdap (tetanus, diphtheria and pertussis) | Intramuscular | 0.5 mL |
| Typhoid | Intramuscular | 0.5 mL |
| Varicella/chickenpox | Subcutaneous | 0.5 mL |
| Yellow fever | Subcutaneous | 0.5 mL |

**Notes**

**Reminder**

1. Update the patient's record with any new allergy, health condition or primary care provider information.
2. Enter vaccine lot #, expiration date and site of administration, then scan the VAR form into the patient's record.

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*5017118 0301 1 0008999 9*

**WAITING**
SAT 12:03PM
**$89.99**

JEFFREY RIEL
745 Westford St
Lowell, MA 018512931
(978)606-9152

**04/06/19**
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**JEFFREY RIEL**
745 WESTFORD ST, LOWELL, MA 018512931
DATE **04/06/19**

**ENGERIX-B 20MCG/ML INJ, 1ML (ADULT)**
MFG GLAXO SMITH KLINE
**ADMINISTER 1ML IN THE MUSCLE AS DIRECTED**

RX **5017118-06739**
QTY **1**
**NO REFILLS - DR. AUTH REQUIRED**

USE BEFORE Mfg. Labeled Date
ORG DATE 04/06/19
JOHN BOGDASARIAN, MD

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| | |
|---|---|
| FSA RX 5017118 | 89.99 |
| TOTAL | 89.99 |
| DEBIT CARD | 89.99 |
| CHANGE | .00 |

AID A0000000980840
US DEBIT
Integrated chip card
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| | |
|---|---|
| TOTAL FSA ITEMS | 0.00 |
| TOTAL RX ITEMS | 89.99 |
| TOTAL FSA AND RX ITEMS | 89.99 |
| APPROVED FSA/HRA AMOUNT | 0.00 |

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BALANCE REWARDS ACCT # *********1776

| | |
|---|---|
| OPENING BALANCE | 1060 |
| EVERYDAY POINTS - RX | 100 |
| CLOSING BALANCE | 1160 |

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