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											

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Jeffrey Riel DOB: 4/30/83

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 #: 32J9R **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): [signature] **Clinician's signature:** [signature] **Title:** Pharmacist

If applicable, intern name (print): ______ **Administration date:** 4/6/19 **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 1 mL: Adults ≥19 years
Hepatitis B	Intramuscular	0.5 mL: Adolescents ≤ 19 years 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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