Vaccine Administration Record

Immunization Type / Vaccine Name: Tdap (Whooping Cough)

Patient Information:

Last Name JIANG First Name XUEWEI Date of Birth 03/13/1993 Gender Female

Address 12421 SANFORD ST,LOS ANGELES,CA,90066

Phone (254) 214-9350

Primary Care Provider (PCP) Name

PCP Address City, State, Zip

Prescriber Name AZAD, ARMAGHAN

Prescriber Address 26520 CACTUS AVE, MORENO VALLEY, CA, 925553927

Store Information:

Store # 03903 Address 3202 WILSHIRE BLVD

RX # 0654930 00 City, State, Zip Santa monica,CA,90403 Telephone (310) 829-5513

Screening Questions:	YES	NO	N/A
1. Are you sick today? (For example: a cold, fever or acute illness)		X	
2. Do you have allergies or reactions to any foods, medications, vaccines or latex? (For example: eggs, gelatin, neomycin, thimerosal, etc.) or have you ever had a severe allergic reaction (e.g., anaphylaxis) to something? For example, a reaction for which you were treated with epinephrine or EpiPen®, or for which you had to go to the hospital? If yes, what are you allergic to?		X	
3. Have you ever had a serious reaction after receiving a vaccination? Do you have a history of fainting, particularly with vaccines? Has any physician or other healthcare professional ever cautioned or warned you about receiving certain vaccines or receiving vaccines outside of a medical setting?		X	
4. Have you had a seizure or a brain or other nervous system problem or Guillain Barre?		X	

CVS pharmacy

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Screening Questions:	**YES**	**NO**
5. Do you have a bleeding disorder or take blood thinners such as Warfarin/Coumadin?		X
6. For Tetanus vaccines, do you have a cut, injury, puncture or open wound that prompted you to get a tetanus shot?		X
7. Are you currently pregnant or breastfeeding or is there a chance you could become pregnant during the next month?		X

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...ONSENT FOR SERVICES: I have received and read (or had read to me) the Patient Fact Sheets and/or Vaccine Information Statements regarding the vaccine. I understand the benefits and risks of vaccination. I voluntarily assume full responsibility for any reactions or consequences that may result. I understand that I should remain in the vaccine administration area for 15 minutes, or longer if directed, after the vaccination to be monitored for potential adverse reactions. In the event of side effects, Iunderstand I should call the pharmacy, my doctor, or 911. I certify that the information provided regarding eligibility for the vaccine is accurate and request that the vaccine be given to me or to the person previously named for whom I am authorized to make this request. State of Georgia only: I verify a pharmacist asked for my health history and whether I have had a physical exam within the past year. Health care providers did not identify condition(s) that would mean I should not receive vaccine(s).

AUTHORIZATION TO REQUEST PAYMENT: I authorize CVS Pharmacy® (¿CVS®¿) to release medical information to Medicare, Medicaid or any other third party payer as needed and to request payment of authorized benefits to be made on my behalf to CVS . I certify that the information provided about may Medicare, Medicaid or other coverage is correct.

ACCEPTANCE OF FINANCIAL RESPONSIBILITY: Notwithstanding anything previously set forth, I agree that I am responsible for and will promptly pay on demand any and all obligations to CVS Pharmacy including all self-pay balances as well as those charges for services not covered or disallowed by my insurance carrier(For non-COVID-19 vaccines).

DISCLOSURE OF RECORDS: I understand that CVS® may be required to or may voluntarily disclose my health information with respect to this vaccine to my healthcare providers, my insurance plan, health systems and hospitals, and/or state or federal registries. I understand that CVS will use and disclose my health information as set forth in the CVS Notice of Privacy Practices (copy is available in-store, online or by requesting a paper copy from the pharmacy). State of California only: I agree to have the California Immunization Registry (CAIR) share my immunization data with health care providers, agencies or schools. State of FL only: Students 18-23 may opt out of the immunization registry by notifying pharmacy prior to administration

X _____ Date: _____

Signature of patient to receive vaccine or person authorized to make the request (parent/guardian)

Vaccine Administration Information:

Administration Date 12/01/2023	Vaccine BOOSTRIX TDAP VACCINE SYRINGE	Manufacturer GLAXOSMITHKLINE
Lot # 324B2	Exp. Date 01/30/2026	Route IM Site Left Deltoid
Volume (ml) 0.5	VIS Version Date 03/31/2020	Date VIS Given to Pt 12/01/2023

Verifying Pharmacist: Bishehban, Parmis

Bishehban, Parmis, Pharmacist

Administering Immunizer Name & Title