



Vaccine Administration Record
Immunization Type / Vaccine Name: Hepatitis B



Patient Information:

Last Name LU

First Name YANXIN

Date of Birth 10/17/1989

Gender Male

Address 12421 SANFORD ST, LOS ANGELES, CA, 90066

Phone (254) 224-1457

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

Telephone (310) 829-5513

RX # 0654929 00

City, State, Zip Santa monica, CA, 90403

Screening Questions:

YES NO N/A

1. Are you sick today? (For example: a cold, fever or acute illness)

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?

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?

4. Have you had a seizure or a brain or other nervous system problem or Guillain Barre?

Last Name LU

First Name YANXIN

Date of Birth 10/17/1989

Screening Questions:

YES NO N/A

5. Do you have a bleeding disorder or take blood thinners such as Warfarin/Coumadin?

6. For Tetanus vaccines, do you have a cut, injury, puncture or open wound that prompted you to get a tetanus shot?

7. Are you currently pregnant or breastfeeding or is there a chance you could become pregnant during the next month?

Immunization Type / Vaccine Name: Hepatitis B

Name LU

First Name YANXIN

Date of Birth 10/17/1989

CONSENT 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, I understand 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 my 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 HEPLISAV-B 20 MCG/0.5 ML SYRNG Manufacturer DYNAX TECHNOLOGIES

Lot # 943007

Exp. Date 09/30/2025

Route IM

Site Left Deltoid

Volume (ml) 0.5

VIS Version Date 10/14/2021

Date VIS Given to Pt 12/01/2023

Verifying Pharmacist: Bishehban, Parmis

Bishehban, Parmis, Pharmacist

Administering Immunizer Name & Title