Immunization Information

Vaccine Information Statements (VIS) must be given to the patient/guardian prior to administering immunizations.
Give patient/guardian opportunity to ask questions

Client Name: [redacted] MCI: 5550434968

DOB: 8/4/1997 Patient Age: 19 Years, 11 Months, 20 Days PCP ID: 371437

SERIES Given	DOSE	VACCINE NAME	DATE Given	Site	Route	Vaccine Manuf	LOT or Control #	VIS DATE	PROVIDER FACILITY	Administered By [Entered By]
HEP B, ADOLESCENT OR PEDIATRIC	1	HEP B	8/4/1997					12/30/1899	HISTORICAL PROVIDER FACILITY	ON DUTY, PROVIDER
HEP B, ADOLESCENT OR PEDIATRIC	2	HEP B	10/6/1997					12/30/1899	HISTORICAL PROVIDER FACILITY	ON DUTY, PROVIDER
HEP B, ADOLESCENT OR PEDIATRIC	3	HEP B	5/6/1998					12/30/1899	HISTORICAL PROVIDER FACILITY	ON DUTY, PROVIDER
DTAP	1	DTAP	10/6/1997					12/30/1899	HISTORICAL PROVIDER FACILITY	ON DUTY, PROVIDER
DTAP	2	DTAP	12/9/1997					12/30/1899	HISTORICAL PROVIDER FACILITY	ON DUTY, PROVIDER
DTAP	3	DTAP	2/4/1998					12/30/1899	HISTORICAL PROVIDER FACILITY	ON DUTY, PROVIDER
DTAP	4	DTAP	12/2/1998					12/30/1899	HISTORICAL PROVIDER FACILITY	ON DUTY, PROVIDER
DTAP	5	DTAP	8/4/2001					12/30/1899	HISTORICAL PROVIDER FACILITY	ON DUTY, PROVIDER
IPV	1	IPV	10/6/1997					12/30/1899	HISTORICAL PROVIDER FACILITY	ON DUTY, PROVIDER
IPV	2	IPV	12/9/1997					12/30/1899	HISTORICAL PROVIDER FACILITY	ON DUTY, PROVIDER
IPV	3	IPV	2/4/1998					12/30/1899	HISTORICAL PROVIDER FACILITY	ON DUTY, PROVIDER
IPV	4	IPV	8/14/2001					12/30/1899	HISTORICAL PROVIDER FACILITY	ON DUTY, PROVIDER
HIB (PRP-T) (ACTHIB / HIBERIX)	1	HIB	10/6/1997					12/30/1899	HISTORICAL PROVIDER FACILITY	ON DUTY, PROVIDER
HIB (PRP-T) (ACTHIB / HIBERIX)	2	HIB	12/9/1997					12/30/1899	HISTORICAL PROVIDER FACILITY	ON DUTY, PROVIDER
HIB (PRP-T) (ACTHIB / HIBERIX)	3	HIB	2/4/1998					12/30/1899	HISTORICAL PROVIDER FACILITY	ON DUTY, PROVIDER
HIB (PRP-T) (ACTHIB / HIBERIX)	4	HIB	12/2/1998					12/30/1899	HISTORICAL PROVIDER FACILITY	ON DUTY, PROVIDER
MMR	1	MMR	8/12/1998					12/30/1899	HISTORICAL PROVIDER FACILITY	ON DUTY, PROVIDER
MMR	2	MMR	8/14/2001					12/30/1899	HISTORICAL PROVIDER FACILITY	ON DUTY, PROVIDER
VARICELLA	1	VAR	8/12/1998					12/30/1899	HISTORICAL PROVIDER FACILITY	ON DUTY, PROVIDER

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VARICELLA	2	VAR	10/3/2007	LEFT DELTOID	SUBCUTANEOUS	MERCK & CO., INC.	1179U	1/10/2007	FLORENCE HEALTH DEPT.	SNIDER, SALLY D
FLU, IIV3, 4YRS+	1	FLU	9/18/2009					12/30/1899	FLORENCE HEALTH DEPT.	
INFLUENZA, H1N1-09	2	FLU	10/30/2009			FLORENCE HEALTH DEPT.		12/30/1899	FLORENCE HEALTH DEPT.	
FLU, IIV3, 4YRS+	3	FLU	10/25/2012	LEFT ARM	INTRAMUSCULAR	GLAXOSMITHKLINE (FORMERLY SMITHKLINE BEECHAM includes GLAXO WELCOME)	AFLU709AA	7/2/2012	FLORENCE HEALTH DEPT.	GASKINS, BARBARA B
FLU, IIV3, 4YRS+	4	FLU	10/13/2014	LEFT DELTOID	INTRAMUSCULAR	NOVARTIS PHARMACEUTICAL CORP. (INCLUDES CIBA-GEIGY LIMITED & SANDOZ LIMITED)	14512P	12/31/1899	DOCTORS CARE- SOUTH IRBY	
Tdap	1	TD	8/17/2015	LEFT DELTOID	INTRAMUSCULAR	SANOFI PASTEUR INC	c4697aa	2/24/2015	MEDICAL PLAZA FAMILY MEDICINE	
MENING (MCV4-MENACTRA)	1	MCV4	8/17/2015	RIGHT DELTOID	INTRAMUSCULAR	SANOFI PASTEUR INC	u5179aa	10/14/2011	MEDICAL PLAZA FAMILY MEDICINE	
MENING (MCV4-MENVEO)	*	MCV4	8/17/2015	RIGHT DELTOID	INTRAMUSCULAR	UNKNOWN MANUF.	U5179AA	12/31/1899	MEDICAL PLAZA FAMILY MEDICINE	

Varicella Disease: [ ] Date Checkbox Checked: Check box if child has a reliable history of Chickenpox**

Next immunizations are due: 9/14/2015

Other Immunizations:

Allergies / Comments:

Practice Name & Address: MEDICAL PLAZA FAMILY MEDICINE
800 E CHEVES ST STE 310 FLORENCE SC 29506 1.

Signature of Person Administering Immunizations Date:

* Invalid Dose
** A reliable history of chickenpox is defined as: 1) interpretation by qualified health care professional of parent/guardian description of chickenpox; 2) diagnosis by qualified health care professional of chickenpox; 3) serologic proof of immunity.