

Vaccine Administration Record for Adults

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

Patient name Evangelia FotiBirthdate 6/11/2000 Chart number _____

PRACTICE NAME AND ADDRESS

**AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102**

P.O. BOX 244023

Vaccine	Type of Vaccine ¹	Date vaccine given (mo/day/yr)	Funding Source (F,S,P) ²	Route ³ and Site ³	LOT: EXP: H4A37 10/18/21	DATE ON: H4A37 10/18/21	DATE GIVEN ⁴	Vaccinator ⁵ (signature or initials and title)
Tetanus, Diphtheria, Pertussis (e.g., Tdap, Td) Give IM. ³					NDC 58160-815-43 Hepatitis A & Hepatitis B (Recombinant) Vaccine TWINRIX® 1 mL Mfd. by GlaxoSmithKline Biologicals 474193			
Hepatitis A (e.g., HepA, HepA-HepB®) Give IM. ³		6/24/19 7/24/19	HepA+B HepA+B	P P	LD/IM LD/IM	3PP42 03/16/22	7/16 7/16	6/24/19 AM 7/24/19 AM
Hepatitis B ¹ (e.g., Engerix-B, Recombivax HB, Heplisav-B, HepA-HepB®) Give IM. ³		6/24/19 7/24/19 1/10/2020	HepA+B HepA+B HepA+B	P P P	LD/IM LD/IM LD/IM	3PP42 03/16/22	7/16 7/16 7/16	6/24/19 AM 7/24/19 AM 6/24/19 AM
Human papillomavirus (HPV2*, HPV4*, HPV9) Give IM. ³					NDC 58160-815-43 Hepatitis A & Hepatitis B (Recombinant) Vaccine TWINRIX® 1 mL Mfd. by GlaxoSmithKline Biologicals 474193			
Measles, Mumps, Rubella (MMR) Give Subcut. ³								
Varicella (chickenpox, VAR) Give Subcut. ³								
Meningococcal ACWY (e.g., MenACWY, MPSV4*) Give MenACWY IM. ³								
Meningococcal B (e.g., MenB) Give MenB IM. ³								

*HPV2, HPV4, and MPSV4 vaccines are no longer available in the U.S., but should be included in patient records for historical purposes.

▶ See page 2 to record influenza, pneumococcal, zoster, Hib, and other vaccines (e.g., travel vaccines).

How to Complete this Record

- With the exception of hepatitis B vaccines, record the generic abbreviation (e.g., Tdap) or the trade name for each vaccine; for hepatitis B vaccines, record the trade name (see table at right).
- Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
- Record the route by which the vaccine was given as either intramuscular (IM), subcutaneous (Subcut [SC]), intradermal (ID), intranasal (NAS), or oral (PO) and also the site where it was administered as either RA (right arm), LA (left arm), RT (right thigh), or LT (left thigh).
- Record the publication date of each VIS as well as the date the VIS is given to the patient.
- To meet the space constraints of this form and federal requirements for documentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and titles.
- For combination vaccines, fill in a row for each antigen in the combination.

Abbreviation	Trade Name and Manufacturer
Tdap	Adacel (Sanofi Pasteur); Boostrix (GlaxoSmithKline [GSK])
Td	Decavac, Tenivac (Sanofi Pasteur); generic Td (MA Biological Labs)
HepA	Havrix (GSK); Vaqta (Merck)
For hepatitis B, see footnote #1.	Engerix-B (GSK); Recombivax HB (Merck); Heplisav-B (Dynavax)
HepA-HepB	Twinrix (GSK)
HPV2*	Cervarix (GSK)
HPV4*, HPV9	Gardasil, Gardasil 9 (Merck)
MMR	MMRII (Merck)
VAR	Varivax (Merck)
MenACWY	Menactra (Sanofi Pasteur); Menveo (GSK)
MPSV4*	Menomune (Sanofi Pasteur)
MenB	Bexsero (GSK); Trumenba (Pfizer)

CONTINUED ON THE NEXT PAGE ▶

Technical content reviewed by the Centers for Disease Control and Prevention

Vaccine Administration Record for Adults (continued)

Patient name _____

Birthdate _____ Chart number _____

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

PRACTICE NAME AND ADDRESS

Vaccine	Type of Vaccine ¹	Date vaccine given (mo/day/yr)	Funding Source (F,S,P) ²	Route ³ and Site ³	Vaccine		Vaccine Information Statement (VIS)		Vaccinator ⁵ (signature or initials and title)
					Lot #	Mfr.	Date on VIS ⁴	Date given ⁴	
Influenza (e.g., IIV3, IIV4, ccIIV4, RIV3, RIV4, LAIV4) Give IIV3, IIV4, ccIIV3, RIV3, and RIV4 IM. ³ Give LAIV4 NAS. ³									
Pneumococcal conjugate (e.g., PCV13) Give PCV13 IM. ³									
Pneumococcal polysaccharide (e.g., PPSV23) Give PPSV23 IM or Subcut. ³									
Zoster (shingles) Give RZV IM ³ Give ZVL Subcut ³									
Hib Give IM.³									
Other									

► See page 1 to record Tdap/Td, hepatitis A, hepatitis B, HPV, MMR, varicella, MenACWY, and MenB vaccines.

How to Complete this Record

1. Record the generic abbreviation (e.g., Tdap) or the trade name for each vaccine (see table at right).
2. Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
3. Record the route by which the vaccine was given as either intramuscular (IM), subcutaneous (Subcut [SC]), intradermal (ID), intranasal (NAS), or oral (PO) and also the site where it was administered as either RA (right arm), LA (left arm), RT (right thigh), or LT (left thigh).
4. Record the publication date of each VIS as well as the date the VIS is given to the patient.
5. To meet the space constraints of this form and federal requirements for documentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and titles.

Abbreviation	Trade Name and Manufacturer
IIV3/IIV4 (inactivated influenza vaccine, trivalent or quadrivalent); ccIIV4 (cell culture-based inactivated influenza vaccine, quadrivalent); RIV3/RIV4 (inactivated recombinant influenza vaccine, trivalent or quadrivalent)	Fluarix, FluLaval (GSK); Afluria, Fluad, Flucelvax, Fluvirin (Seqirus); Flublok, Fluzone, Fluzone Intradermal, Fluzone High-Dose (Sanofi Pasteur)
LAIV (live attenuated influenza vaccine, quadrivalent)	FluMist (MedImmune)
PCV13	Pneumovax 13 (Pfizer)
PPSV23	Pneumovax 23 (Merck)
RZV (recombinant zoster vaccine) ZVL (zoster vaccine, live)	Shingrix, RZV (GSK); Zostavax, ZVL (Merck)
Hib	ActHIB (Sanofi Pasteur); Hiberix (GSK); PedvaxHib (Merck)



Alabama Department of Public Health

CERTIFICATE OF IMMUNIZATION

EVANGELIA GRACE FOTI

Child's Name (first, middle, last)

06/11/2000

Birthdate

8/30/2021
Date of Expiration

(Next Required Immunization)

Parent/Guardian Name (first, middle, last)

Unless Specifically exempted by law, Alabama law (code of Alabama 1975, Section 16-30-4) requires a certificate on file for each child in attendance in all schools and licensed child care facilities in Alabama. Instructions for this form and immunization requirements by age are detailed via the ADPH web site at www.adph.org/immunization

Vaccine	DOSE1 DATE MM DD YY	DOSE2 DATE MM DD YY	DOSE3 DATE MM DD YY	DOSE4 DATE MM DD YY	DOSE5 DATE MM DD YY	DOSE6 DATE MM DD YY	Total Doses	Confirmed Lab MM YY	History MM YY
Required Vaccines for School or Child Care Attendance									
DTP,DTaP,DT	DTAP 09/20/00	DTAP 10/20/00	DTAP 11/20/00	DTAP 06/27/02	DTAP 04/29/05				
TD									
Tdap	TDAP 07/22/11								
IPV,OPV	IPV 08/21/00	IPV 09/20/00	IPV 10/20/00	IPV 04/29/05					
Hib (Under Age 5)	HIB 08/23/01								
Measles	MMR 10/02/01	MMR 04/29/05							
Mumps	MMR 10/02/01	MMR 04/29/05							
Rubella	MMR 10/02/01	MMR 04/29/05							
PCV									
Varicella	VARICELLA 10/02/01	VARICELLA 11/01/13							

Recommended Vaccines									
HepA									
HepB									
HPV									
MCV, MPSV,MENB	MCV4P 07/22/11	MCV4P 7/22/11							
Rotavirus									

NOTES

A licensed physician or qualified employee of the Alabama Dept of Public Health is responsible for the content of this certificate. All dates must include the month, day, and year. In cases of history of disease or laboratory confirmation, the month and year of infection or test must be filled in the appropriate box(es).

The certificate is NOT valid without the name and birth date of the child, date of expiration, name and address of the physician or health department, and date of issue. A school or facility official is responsible for keeping a current valid Certificate on file for each child in attendance. When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian.

Site Name : PARTNERS IN PEDIATRICS LLC
MONTGOMERYAddress: 8160 SEATON PLACE
MONTGOMERY

Telephone #: (334) 2721799

Date of Issue: 7/14/2017

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Evangelia Foti

DATE OF BIRTH 06 / 11 / 00
month day year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☒	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☒	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☒	☐
4. Do you have a long-term health problem with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	☐	☒	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☒	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☒	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☒	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☒	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☒	☐

FORM COMPLETED BY Evangelia Foti DATE 01/10/20
FORM REVIEWED BY M. Hagg DATE 1/10/2020

Did you bring your immunization record card with you? yes ☒ no ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Evangelia Foti

DATE OF BIRTH 06 / 11 / 2000
month day year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☒	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☒	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☒	☐
4. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	☐	☒	☐
5. Do you, or does a close family member, have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
6. In the past 3 months, have you taken medications that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☒	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☒	☐
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☒	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☒	☐
10. Have you received any vaccinations in the past 4 weeks?	☒	☐	☐

FORM COMPLETED BY Evangelia Foti DATE 01/10/20
FORM REVIEWED BY [Signature] DATE 7/24/19

Did you bring your immunization record card with you? yes ☒ no ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.