

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Lucy Williams
DATE OF BIRTH 10 / 16 / 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, 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 Lucy Williams DATE 8/2/19
FORM REVIEWED BY lgon DATE _____

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.

AUM Student Health Services

Immunization Record

Patient Name: Lucy Williams

Birthdate: _____

Allergies/Medical Alert: _____

Immunization	Date	Site	Dose	MFR	Comments	Visit Date	Initials
Tdap							
Td Booster							
MMR							
HEP A							
HEP B							
mcv4	8/2/19	RD	0.5cc	Mentira ² NDC #01-589-58 Mid by: Soli Pasteur Inc. (U) U655CA			AM
Other							

Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	Date Given	Date Read	Results	MFR	LOT#	Comments	Initials

Initials	Signature	Initials	Signature
AM	<i>[Signature]</i>		

STAMP ABOVE

Alabama Department of Public Health

CERTIFICATE OF IMMUNIZATION

LUCY EMERSON WILLIAMS
Child's Name (first, middle, last)

10/16/2000
Birthdate

7-31-2022
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, Td,TdaP	DTAP 12/15/00	DTAP 02/19/01	DTAP 04/23/01	DTAP 01/28/02	DTAP 10/17/05	Tdap 7-11-12			
IPV,OPV	IPV 12/15/00	IPV 02/19/01	IPV 01/28/02	IPV 10/17/05					
Hib (Under Age 5)	HIB 12/15/00	HIB 02/19/01	HIB 04/23/01	HIB 01/28/02					
Measles	MMR 10/22/01	MMR 10/17/05							
Mumps	MMR 10/22/01	MMR 10/17/05							
Rubella	MMR 10/22/01	MMR 10/17/05							
PCV	PCV7 02/19/01	PCV7 04/23/01	PCV7 07/16/01	PCV7 01/28/02					
Varicella	VAR 10/22/01	7-11-12							

Recommended Vaccines									
HepA	7-11-12								
HepB	HEP B 04/23/01	HEP B 07/16/01	HEP B 10/22/01						
HPV									
MCV or MPSV	7-11-12								
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 in the month, day, and year. In cases of history of disease or laboratory confirmation, the 4 digit 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, legible name and address of the physician or health department, certified by signature, and the date of issue. A school or facility official is responsible for keeping a current valid Certificate on the 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.

Clinic Name : PARTNERS IN PEDIATRICS
LLC MONTGOMERY

Address: 8160 SEATON PLACE
MONTGOMERY 36116

Telephone #: (334)272-1799

Catherine L. Woodard

Certified by (Signature)

7/11/2012
Date of Issue