

Carol Stewart, C.R.N.P.
Lic. #1-045437
Rx: 1178

AUBURN MONTGOMERY
STUDENT HEALTH CENTER
P. O. Box 244023
Montgomery, AL 36124-4023
(334) 244-3281

Ramona Lazenby, C.R.N.P.
Lic. #1-039092
Rx: 0703

Darlene Pierce, C.R.N.P.
Lic. #1-134315
RX: 3692

Maryluz Fuentes, M.D.
(334) 286-3444
DEA #BF 6451520
AL #24127

Name Jonathan Robertson Date 8/18/14

Address _____

Rx

Doxycycline 100mg

Disp: 42

Sig: One pill a day; begin 2 days before
departure, continue through stay and
for four weeks after return.

Laura Stewart
M.D. or C.R.N.P.

Product Selection Permitted

Label all prescriptions

Refill: 1 2 3 5 PRN NR

Dispense As Written _____, M.D. or C.R.N.P.

Patient name: Jonathan Robertson Date of birth: 8/18/14
(mo.) (day) (yr.)

Screening Checklist for Contraindications to Vaccines for Adults

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 weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, 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: Jonathan Robertson Date: 8-18-14
Form reviewed by: [Signature] Date: 8/18/14

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.



Auburn University Montgomery
Student Health Services

Hepatitis A and B Reminder

Date: 1/3/13

Dear Mr. Robert Son:

Your final Hepatitis A and B (Twinrix) vaccine was due on

Dec 28, 2012.

Please call the Nursing Care Center for an appointment as soon as possible at 244-3281 to continue receiving your immunization as scheduled.

Thank you for allowing us to participate in the protection of your good health.

Sincerely,

A handwritten signature in cursive script, appearing to read 'Amy Morris'.

Amy Morris, M.P.A., B.S.N., R.N., B.C.
AUM-Nursing Care Center



Auburn University Montgomery

Student Health Services

Hepatitis A and B Reminder

Date: 11/30/12

Dear Mr. Robertson:

Your final Hepatitis A and B (Twinrix) vaccine is due on Dec 28, 2012. Please call the Nursing Care Center for an appointment as soon as possible, at 244-3281 to continue receiving your immunization as scheduled.

In order for your immunization against Hepatitis A and B to be continued within the recommended schedule, you must have your final dose by

Jan 11, 2013.

Thank you for allowing us to participate in the protection of your good health.

Sincerely,

Amy Morris, M.P.A., R.N., B.C.
AUM-Nursing Care Center

Patient name:

Jonathan Robertson

Date of birth:

1/18/80
(mo.) (day) (yr.)

Screening Questionnaire for Adult Immunization

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, AIDS, or any other immune system problem?	☐	☒	☐
6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, 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:

Jonathan Robertson

Date:

8-1-12

Form reviewed by:

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.

Technical content reviewed by the Centers for Disease Control and Prevention, October 2010.

www.immunize.org/catg.d/p4065.pdf • Item#P4065 (10/10)

Immunization Action Coalition • 1573 Selby Ave. • St. Paul, MN 55104 • (651) 647-9009 • www.immunize.org • www.vaccineinformation.org



Auburn University Montgomery

Student Health Services

Hepatitis A and B Reminder

Date: July 1, 2012

Dear Mr. Robertson:

Your second Hepatitis A and B (Twinrix) vaccine is due on July 27, 2012. Please call the Student Health Center at Auburn Montgomery for an appointment as soon as possible at 244-3281, to continue receiving your immunization as scheduled.

In order to stay within the recommended schedule, you should receive your next dose by Aug 10, 2012.

Thank you for allowing us to participate in the protection of your good health.

Sincerely,

Amy Morris, RN-BC

Amy Morris, RN-BC
AUM-Nursing Care Center

Carol Stewart, C.R.N.P.
Lic. #1-045437
Rx: 11/8

AUBURN MONTGOMERY
STUDENT HEALTH CENTER
P. O. Box 244023
Montgomery, AL 36124-4023
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Ramona Lazenby, C.R.N.P.
Lic. #1-039092
Rx: 0703

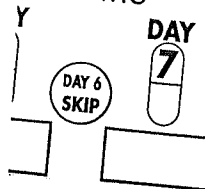
Stacey E. White, C.R.N.P.
Lic. #1-077155
RX: 1501

Maryluz Fuentes, M.D.
(334) 286-3444
DEA #BF 6451520
AL #24127

COT-V17-CVRS RV (12-09)
RP (4-1-11)

Room Mirror

Vaccine



Crucell

Name Jonathan Robertson Date 6/28/12

Address _____

Rx Vivotif

Disp: 4 doses

Sig: Take as directed

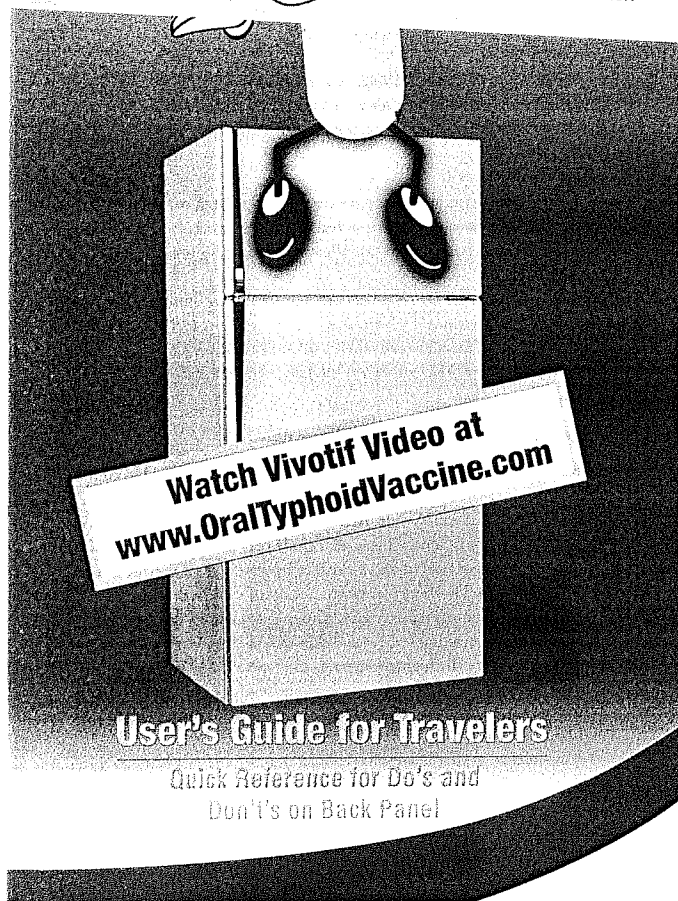
[Signature]
Product Selection Permitted, M.D. or C.R.N.P.

Label all prescriptions

Refill: 1 2 3 5 PRN NR

Dispense As Written, M.D. or C.R.N.P.

Use | Storage



typhoid fever.

as directed, usually one capsule is taken every other day for 4 days. Take with lukewarm drink one hour before a meal. Swallow capsule as directed. Do not chew it or take it with warm or hot liquid. Replace any broken capsules. If completely effective, your course of treatment should be completed.

Headache or mild fever may occur. If these symptoms continue or worsen, contact your doctor if the following effects occur: breathing or swallowing difficulties, rash, and severe tiredness. If you notice other effects not listed above, contact your doctor.

Avoid use if you have any of the following conditions: illness, infection, allergies, or if you are pregnant. Should be used during pregnancy only if clearly needed. Discuss with your doctor if you are breastfeeding. Known if this medication appears in breast milk. Consult your doctor.

Avoid use if you are taking any over-the-counter or prescription medication you may take, including cancer drugs, immunosuppressants, sulfa drugs, antibiotics, other drugs, or if you are taking any of these without doctor or pharmacist approval.

Keep out of reach of children. If you experience severe allergic reaction, contact your local poison control center or emergency room immediately. Toll-free number 1-800-222-1222. Canadian residents should call their local poison control center.

Effective in preventing typhoid fever, depending partly on the degree of exposure. Take all necessary precautions to avoid contact or ingestion of potentially contaminated food or water.

MISSED DOSE: If you miss a dose, take it as soon as remembered; do not take it if it is near the time for the next dose, instead, skip the missed dose and resume your usual dosing schedule. If you miss more than one dose, contact your doctor to establish a new dosing schedule. Do not "double-up" the dose to catch up.

STORAGE: Store capsules under refrigeration at all times as directed. Keep away from heat and light. Do not store in the bathroom.

**AUM NURSING CARE CENTER
PROBLEM VISIT RECORD**

DATE: 6/28/12 TIME: 2¹⁰ PT. HISTORY REVIEWED / UPDATED 1 / 1

PATIENT NAME: Jonathan Robertson DOB: _____ AGE: _____

PRESENT COMPLAINT: Pt traveling to Kenya in August on a mission trip and is needing travel vaccines. Has no known health problems that increase his risk for an adverse reaction to the yellow fever vaccine. Discussed possible

VITALS:						LMP:
Temp	Pulse	Resp	B/P	HT	WT	Allergies
						NKMA.

INITIAL VISIT		RETURN VISIT
side effects and adverse reactions to the vaccine at length.		
Reviewed instructions for the oral typhoid vaccine. Pt received reminder stickers, information sheet and brochure. Pt verbalized understanding.		
After receiving vaccines, pt stated he felt light headed. Was given a soda and legs were elevated. Pt was monitored for over 20 minutes. stated he feels this way from donating blood. Pt recovered and left clinic at 15 ⁰⁵ AM.		

DIAGNOSIS:	TESTS	RESULTS

CALL BACK: _____

INITIATOR: _____ STAFF SIGNATURE: kgow

DATE: _____ COMMENTS: _____

ACUM STUDENT HEALTH CENTER
TRAVEL HEALTH HISTORY

Date 6-28-12 Name Jonathan Robertson

1. What is the reason for your visit today vaccination for trip to Kenya, Africa
2. List allergies you have to medicines, foods or iodine: none
3. List any medications or drugs you are currently taking (this would include herbal and over-the-counter as well as prescription drugs): n/a
4. Have you had any of the following: (circle if this applies to you;):
 - Heart disease _____
 - Kidney disease _____
 - Stomach/Gastrointestinal disease _____
 - Diabetes/sugar _____
5. Are you immunocompromised? (Is there a problem with your immune system) Yes _____ No X
 - Thymus disorder (Myasthenia gravis, thymoma, thymectomy) _____
 - Spleen removed _____
 - Transplant recipient _____
 - Cirrhosis of the liver _____
 - Cancer _____
 - HIV _____
6. How often do you drink beer, wine, ~~wine cooler~~, or liquor? (Please circle)
Never / Rarely / 1-2 times a week / 3-4 times a week / 5 or more times a week
7. Where are you going on your trip? Kenya, Africa
8. How long is your trip? Months _____ Days 10
9. When are you leaving on your trip? August 3, 2012

FOR FEMALES ONLY

- A. Date of your last period? _____ Have you had a hysterectomy? YES _____ NO _____
- B. Are you currently pregnant? YES _____ NO _____
What is your due date? _____
- C. Do you plan to become pregnant in the next 3 months? YES _____ NO _____
- D. Are you breastfeeding? YES _____ NO _____

Auburn Montgomery Student Health Center

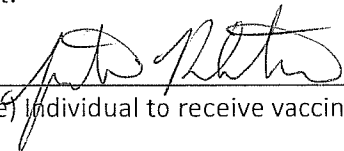
Consent for Yellow Fever Vaccine

I hereby give my consent to be vaccinated against Yellow Fever. I have been given information and an opportunity to ask questions about the vaccine and the risks involved. All my questions have been answered to my satisfaction. I have been informed that persons are at an increased risk for a reaction if they are:

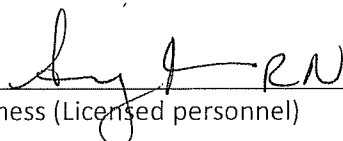
- 1) Allergic to a component to the vaccine;
- 2) Over age 60;
- 3) Have thymus disorder or disease; or
- 4) Are immunocompromised (by HIV, cancer or medications, etc.).

Further, pregnant and breast-feeding women should not take the vaccine without consulting their OB-GYN or pediatrician. I understand that I may consult with my private physician about the vaccine should I desire to do so. I understand that as with all medical treatments, there is no guarantee that I will not experience an adverse effect.

Jonathan Robertson
Printed Name (Individual to receive vaccine)


(Signature) Individual to receive vaccine

6-28-12
Date

 RN
Witness (Licensed personnel)

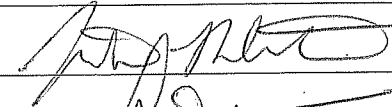
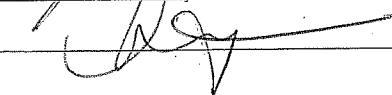
6/28/12
Date

Patient name: Jonathan RobertsonDate of birth: 1/18/80
(mo.) (day) (yr.)

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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, AIDS, or any other immune system problem?	☐	☒	☐
6. Do you take cortisone, prednisone, other steroids, or anticancer drugs, 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: Date: 6-28-12Form reviewed by: Date: 10/28/12

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

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