

Clinic: _____

Name: Blake Cohen

Date of Birth: 3/14/95 Record #: _____

Allergies: NKA Reactions: _____

History of Chickenpox? YES or NO If yes, date if known: _____

Vaccine	Date Admin			Age at the time	VIS Form Given			Manuf Abbr*	Lot Number	Dose	Admin Site**	Route	Provider Initials*** or Outside Provider Name
	Mo	Day	Yr		Type	Mo	Yr						
Td					Td			LOT: 5397F EXP: 12/06/21		0.5cc		IM	
Td					Td					0.5cc		IM	
Td					Td			NDC 58160-821-43 Hepatitis B Vaccine (Recombinant) ENGRIX-B®		0.5cc		IM	
Td					Td					0.5cc		IM	
Tdap					Tdap			20 mcg/mL		0.5cc		IM	
Hep B					Hep B			Mfd by GlaxoSmithKline Biologicals				IM	
Hep B	2	19	20		Hep B	7	16	474430		1.0	RD	IM	AM
Hep B	7	21	20		Hep B	7	16			1.0	LD	IM	AM
Hep B (booster if needed)					Hep B			LOT: 9P9B5 EXP: 02/07/22				IM	
MMR Rubella Rubeola					MMR			NDC 58160-821-43		0.5cc		SQ	
MMR Rubella Rubeola					MMR			Hepatitis B Vaccine (Recombinant) ENGRIX-B®		0.5cc		SQ	
Varicella					Var			20 mcg/mL		0.5cc		SQ	
Varicella					Var			Mfd by GlaxoSmithKline Biologicals		0.5cc		SQ	
IPV					Polio			495702		0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
PPV23					PPV					0.5cc		IM	
PPV23					PPV					0.5cc		IM	
Hepatitis A					Hep A							IM	
Hepatitis A					Hep A							IM	
HPV					HPV					0.5cc		IM	
HPV					HPV					0.5cc		IM	
HPV					HPV					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
MCV4					Mening							IM	
MPSV4					Mening							SQ	

* Manufacturers: M= Merck; S= Sanofi Pasteur; W= Wyeth; G= GlaxoSmithKline

** Sites: LT = Left Thigh, RT = Right Thigh, LA = Left Arm, RA = Right Arm, LD = Left Deltoid, RD = Right Deltoid

*** VIS Language given, if not English: _____

AM - Kwon

7

[illegible]

Tuberculin Test

[illegible]

Titer Test Results for Non Susceptibility (IgM)

Date			Disease	Results		Notes							
Mo	Day	Yr		Neg	Pos								

[illegible]

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Blake H Chen
DATE OF BIRTH 03 / 14 / 1995
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 Blake H Chen DATE 7-21-20

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.



Hepatitis B Reminder

Date:

Dear Blake

Your third Hepatitis B vaccination is due on 7/19/2020.
It is important that you continue your series within the recommended schedule to obtain the maximum effect from your vaccination.

In order to achieve maximum benefits, you should receive your vaccine no later than
7/31/2020.

If you have received this immunization elsewhere, please notify us, so that we will take you off our reminder list.

If you wish to continue this immunization with the AUM Student Health Center, please call the clinic to schedule 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, 
Amy Morris, BSN, RN-BC

**AUM Student Health Services
Immunization Record**

Patient Name: Blake Cohen

Birthdate: 3/14/95

Allergies/Medical Alert: _____

Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
Tdap							
Td Booster							
MMR							
HEP A							
HEP B	1/16/20	RD	1.0			7/16	AM
Other							



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

Initials	Signature	Initials	Signature
AMC	Blake Cohen		

**AUBURN UNIVERSITY MONTGOMERY
 STUDENT HEALTH CENTER
 IRMA B. MOORE HALL RM. 102
 P.O. BOX 244023
 MONTGOMERY, AL 36124-4023**

STAMP ABOVE

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MONTGOMERY, AL 36124-4023