

AUM STUDENT HEALTH CENTER
TRAVEL HEALTH HISTORY

Date 1/30/19 Name Betsy Johns

1. What is the reason for your visit today traveling to Haiti
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): None
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 _____
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? Haiti
8. How long is your trip? Months _____ Days 5
9. When are you leaving on your trip? 2/14/19

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 _____

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Betsey Johns

DATE OF BIRTH 12/18/70
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 Betsey Johns DATE 1/30/19

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.

immunization
action coalition



Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

Technical content reviewed by the Centers for Disease Control and Prevention

www.immunize.org/catg.d/p4065.pdf • Item #P4065 (8/17)

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 Betsey Johns Date 1/30/19
Address _____

R_x

Malarone 250/100mg

Disp: 14

Sig: Take one pill a day. Begin 2 days before
departure, continue through stay and
for 7 days after return.

[Signature], 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.

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(334) 286-3444
DEA #BF 6451520
AL #24127

Name Kingsley Johns Date 1/30/19
Address _____

R_x

Malarone 250/100mg

Disp: 14

Sig: Take one pill a day. Begin 2 days before
departure, continue through stay and
for 7 days after return.

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

Label all prescriptions

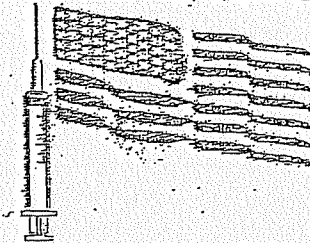
Refill: 1 2 3 5 PRN NR

Dispense As Written

_____, M.D. or C.R.N.P.

ADOLESCENT & ADULT IMMUNIZATION RECORD CLINIC:

Protect Our Future!



Name: Betsey Johns

Date of birth: 12/18/70 Record # _____

Allergies: NKMA

Reactions: _____

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

Immunize!

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					0.5cc		IM	
Td					Td					0.5cc		IM	
Td					Td					0.5cc		IM	
Td					Td					0.5cc		IM	
Tdap	6	4	15	44	Tdap	2	15	SP		0.5cc	RD	IM	AM
Hep B					Hep B							IM	
Hep B					Hep B							IM	
Hep B					Hep B							IM	
Hep B (booster if needed)					Hep B							IM	
MMR Rubella Rubeola					MMR					0.5cc		SQ	
MMR Rubella Rubeola					MMR					0.5cc		SQ	
Varicella					Var					0.5cc		SQ	
Varicella					Var					0.5cc		SQ	
IPV					Polio					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	6	4	15	44	Hep A	10	11	ESK Y4RS9		1.0	LD	IM	AM
Hepatitis A	1	30	19		Hep A	10	16	ESK		1.0	LD	IM	AM
HPV					HPV							IM	
HPV					HPV							IM	
HPV					HPV							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: _____



Hepatitis A Reminder

Date: 12/3/15

Dear Mrs. Johns

Your final Hepatitis A vaccination is due on 12/4/15.
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
12/18/15.

If you have received this immunization elsewhere, please submit a copy for our records.
If you wish to continue the series at the AUM Nursing Care Center, contact our clinic at 244-3281 to set up an appointment at your earliest convenience.

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

Sincerely,

Amy Morris, RN

Amy Morris, MPA, RN-BC

Patient name: Betsey Johns Date of birth: 12/18/70
(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: Betsey Johns

Date: 10/4/15

Form reviewed by: [Signature]

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.

STUDENT HEALTH CENTER
TRAVEL HEALTH HISTORY

Date 10/4/15 Name Petsey Johns

1. What is the reason for your visit today? Traveling Shots
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): None

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 ☒

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? Haiti

8. How long is your trip? Months _____ Days 7

9. When are you leaving on your trip? July 4th

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 _____

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(334) 286-3444
DEA #BF 6451520
AL #24127

Name Betsey Johns Date 6/4/15

Address _____

R

Malarone 250/100mg

Disp: 16

Sig: Take one pill a day. Begin 2 days before
departure, continue through stay and
for 7 days after return.

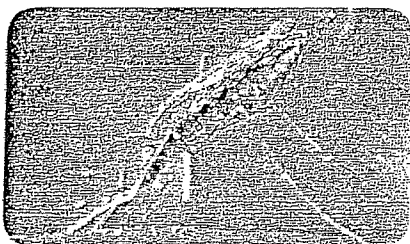
L. Stewart M.D. or C.R.N.P.
Product Selection Permitted

Label all prescriptions

Refill: 1 2 3 5 PRN NF

Dispense As Written

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



Who can take atovaquone-proguanil?

Atovaquone-proguanil can be prescribed to adults and children who weigh at least 11 pounds (5 kg).

Who should not take atovaquone-proguanil?

Pregnant women, women who are nursing infants less than 5kg, or infants who weigh less than 5kg should not take atovaquone-proguanil. Also, people with severe kidney disease should not take atovaquone-proguanil.

How should I take atovaquone-proguanil?

Both adults and children should take one dose of atovaquone-proguanil per day starting a day or two before traveling to the area where malaria transmission occurs. They should take one dose per day while there, and for 7 consecutive days after leaving. In rare instances (such as if you switched to atovaquone-proguanil from another malaria medicine) your doctor may instruct you to take it for a longer period of time.

The daily dosage for adults is a single adult tablet.

en depends on their weight.
aily dose for children based

e a ½ pediatric tablet daily,
et daily
et daily
lets daily
lets daily

ould be taken with food or a

atovaquone-

Antimalarial drugs are available in the United States by prescription only. Medicines should be obtained at a pharmacy before travel rather than in the destination country. Buying medications abroad has its risks: the drugs could be of poor quality, contaminated, or counterfeit and not protect you against malaria.

In what parts of the world can atovaquone-proguanil be used for prevention of malaria in travelers?

Currently atovaquone-proguanil can be taken in any part of the world where malaria occurs.

CDC keeps track of all the places in the world where malaria transmission occurs and the malaria drugs that are recommended for use in each place. This information can be found using the malaria map on the CDC website: <http://www.cdc.gov/malaria/map/index.html>.

