

**AUM Student Health Services
Immunization Record**

Patient Name: MALACHI TOWLE

Birthdate: 06/16/2001

Allergies/Medical Alert:

Immunization	Date	Site	Dose	MFR	Comments	V.I.S.	Initials
Tdap							
Td Booster							
MMR	8/13/2020	Lt. Arm	0.5ml SQ Merck	Exp. 10/7/2021	S031483		LB
HEP A							
HEP B							
Other							

Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	Date Given	Date Read	Results	MFR	LOT#	Comments	Initials
	8/11/2020	8/13/2020	0mm	Sanofi	C5714AA	Lt. Forearm	LB

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

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

STAMP ABOVE

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/15/2013 BY 60322

REASON: 25X(1) DURING THE PERIOD OF REVIEW

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

VERBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM 102
P.O. BOX 2000
MONTGOMERY, AL 36104-0002

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Malachi Towle

DATE OF BIRTH 06/16/2001
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 Malachi Towle

DATE 08/13/20

FORM REVIEWED BY [Signature]

DATE 8/13/2020

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.