

**AUM Student Health Services
Immunization Record**

Patient Name: KANESHA PIERCE

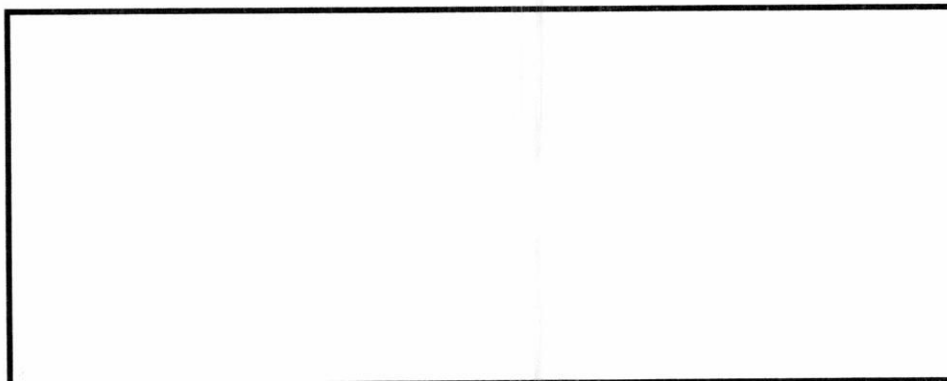
Birthdate: 03/08/1995

Allergies/Medical Alert: Bactrim/PCN

Immunization	Date	Site	Dose	MFR	Comments	V.I.S.	Initials
Tdap	8/12/2020	RD	0.5	GSK	Lot 4PCTG Exp 8/19/2022	2/2015	MAA
Td Booster							
MMR							
HEP A							
HEP B							
Other							

	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	8/12/2020	8/14/2020	0mm	SP	C5714AA	(L)FA	MAA

Initials	Signature	Initials	Signature
MAA	MAA, CRNP		



STAMP ABOVE

ADULT IMMUNIZATION RECORD

Allergies: Bactrim / PCN

Reactions:

Name: PIERCE, KANESHA ELIZABETH

DOB: 03/08/1995

Chart #: _____

Date of Service: 08/12/2020

Vaccine Family	Type of Vaccine (no Brand Name)	Date Given (mm/dd/yy)	Age at Adm	Dose (cc/mL)	Route & Site	Mfr.	Lot #	VIS Date	Vaccinator Signature
Tetanus, Diphtheria, (Pertussis) (e.g., Td, Tdap)	DTP	05/11/95	2 m	0.5					
	DTP-HIB	07/13/95	4 m	0.5					
	DTP-HIB	09/12/95	6 m	0.5					
	DTP	03/15/96	12 m	0.5					
	DTAP	09/21/98	3 y	0.5					
	DTAP	05/26/99	4 y	0.5					
	TD	03/08/06	11 y	0.5					
Hepatitis A (e.g., HepA, HepA-HepB)	HEP A	03/21/07	12 y	0.5					
	HEP A	12/01/09	14 y	0.5					
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	HEP B ADOL/PED	03/08/95	0 m	0.5					
	HEP B ADOL/PED	04/06/95	0 m	0.5					
	HEP B ADOL/PED	09/12/95	6 m	0.5					
Human Papillomavirus (e.g., HPV)	HPV (GARDASIL)	03/21/07	12 y	0.5					
	HPV (GARDASIL)	07/31/09	14 y	0.5					
	HPV (GARDASIL)	12/01/09	14 y	0.5					
Measles, Mumps, Rubella (MMR, MMRV)	MMR	09/21/98	3 y	0.5					
	MMR	04/19/00	5 y	0.5					
Meningococcal (MCV4, MPSV4)	MCV4P (MENACTRA)	07/31/09	14 y	0.5					
Pneumococcal (e.g. PCV, PPV)									
Polio (e.g., IPV, DTaP-HepB-Hib)	OPV	05/11/95	2 m	0.5	PO				
	OPV	07/13/95	4 m	0.5	PO				
	OPV	03/15/96	12 m	0.5	PO				
	OPV	09/21/98	3 y	0.5	PO				
	OPV	05/26/99	4 y	0.5	PO				
Varicella (Var, MMRV)									
Influenza (e.g., TIV, LAIV)									
Zoster									
Other	HIB (HBOC)	05/11/95	2 m	0.5					
	HIB (HBOC)	03/15/96	12 m	0.5					
	HIB UNS	09/21/98	3 y	0.5					

AUM STUDENT HEALTH SERVICES
7461 EAST DRIVE
RM 102 MOORE HALL
MONTGOMERY, AL36117
334 2443281

PPD	Date	Results	PPD	Date	Results
Mantoux			Maxtoux		
Mantoux			Mantoux		
Mantoux			Mantoux		

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME Kanesha Pierce

DATE OF BIRTH 3 / 8 / 1995
month day year

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child 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. Is the child sick today?	☐	☒	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☒	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☒	☐
4. Does the child have lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy? <u>Asthma</u>	☒	☐	☐
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☒	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☒	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☒	☐
8. Does the child or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problems?	☐	☒	☐
9. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☒	☐
10. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☒	☐
11. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☒	☐
12. Has the child received vaccinations in the past 4 weeks?	☐	☒	☐

FORM COMPLETED BY Kanesha Pierce

DATE 8/12/2020

FORM REVIEWED BY M. J. CRP

DATE 8/12/2020

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

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.