

Immunization Form

To ensure the health and safety of our campus, immunizations against communicable diseases is extremely important. Vaccination against Measles, Mumps, Rubella (MMR), Tetanus, Diphtheria and Pertussis (Tdap), and proof of negative Tuberculosis is required of all students entering Auburn Montgomery. This form must be completed and is the preferred document for proof of immunizations and TB testing.

Complete and Return to: **Student Health Center**
Attn: Immunizations
PO Box 244023
Montgomery, AL 36124
(334) 244-3281 Fax (334) 244-3396

Name Delapiedra Tatiana P. Student Number 500377089
Address 2928 US Highway 31N Marbury AL 36051
Street City State Zip Code
Phone Number 334.300.3870 E-mail Address tatypdelapiedra@gmail.com Date of Birth 08/25/85 Date of Enrollment 10/15/20

REQUIRED IMMUNIZATIONS tpagnin@aum.edu

Tuberculosis Screening (within 6 months prior to semester student is to begin at AUM.)

Date Given _____ (Date of reading, within 48 to 72 hours of date given) TB skin test (PPD) _____

Results: Positive _____ mm Negative _____ mm

If positive, you must attach a radiology report from chest X-ray and documentation of treatment.

Tetanus, Diphtheria, Pertussis (Tdap) Vaccine. Students without previous documentation of a Tdap vaccine should have one dose within the last 10 years. Other students should be current to maintain their status throughout their entire academic career.

Date of Tdap vaccine: 01/22/90

Measles, Mumps, Rubella (MMR)

Auburn Montgomery University requires that all students born after 1956 must have had 2 doses of a measles containing vaccine (MMR) prior to registration. One dose must have been after 1980. Lab antibody titers (IgG) for Measles, Mumps and Rubella are acceptable. Please attach documentation to the back of the form.

Date of First Dose 05/28/86

Date of Second Dose 05/18/87

04/30/2004

08/29/2008

OPTIONAL IMMUNIZATIONS (These immunizations are not required by the university but are recommended by the American College Health Association.)

Hepatitis B: 09/13/2001 07/17/02 11/07/02
1st 2nd 3rd

Varicella (Chickenpox) Vaccine: _____ / _____ / _____
1st 2nd

Meningococcal (MenACWY) Vaccine: _____ / _____ / _____ (One dose on or after the 16th birthday)
1st 2nd

Meningococcal B Vaccine _____ / _____ / _____

I certify that the above dates and vaccinations are true.

Signature of Licensed Health Care Professional

Date

License Number or Office Stamp

(Adopted 1/12, Revised 8/2016)

ESQUEMA BÁSICO DE VACINAÇÃO								
VACINAS		Contrapólio	Tríplice (DPT)	Contra Sarampo	B.C.G.	Toxóide Tetânico	Dupla	Outras Vacinas
1ª	Data Local Rubrica	25/10/85 aguen 04201	25/10/85 aguen 04201	28/05/86 aguen 04201	21/01/86 aguen 04201	13/09/01 Cenaf 04201	11/07/02 aguen 04201	FEVERVACINIA 18/07/02 10150430/FA0010 ASB/Camp 04201
2ª	Data Local Rubrica	15/01/86 aguen 04201	15/01/86 aguen 04201	18/05/87 aguen 04201		17/07/02 aguen 04201	20/12 aguen 04201	04 aguen 04201
3ª	Data Local Rubrica	17/03/86 aguen 04201	17/03/86 aguen 04201	30/14/04 S.C.R. 04201		07/11/02 aguen 04201		26/05/17 Fluorix Tetra aguen 04201 Val: 12-2017
R E F F O R C O	Data Local Rubrica	23/05/87 aguen 04201	01/07/87 aguen 04201					
R E F F O R C O	Data Local Rubrica	22/09/90 aguen 04201	22/09/90 Cen 04201					

GOVERNO DO ESTADO DE SÃO PAULO
SECRETARIA DE ESTADO DA SAÚDE
CENTRO DE VIGILÂNCIA EPIDEMIOLÓGICA
"Prof. Alexandre Vannias"

Comprovante de Vacinação
Campanha

POSTO DE VACINAÇÃO
INSTITUTO PASTEUR S.P.
SARAMPO/RUBEOLA

NOME
Tatiane Lage mini Delafedda

VACINAÇÃO REALIZADA
1-24
25/09/08
28/10/08

CONFROVANTE DE VACINAÇÃO - CAMPANHA
03/03/2008
A. S. COREL

Calendário de Vacinação para o Estado de São Paulo

IDADE	VACINAS
1 mês*	BCG
2 meses	DPT e poliomielite
4 meses	DPT e poliomielite
6 meses	DPT e poliomielite
9 meses	Sarampo
15 meses	DPT, poliomielite e sarampo
5 ou 6 anos	DPT e poliomielite
15 anos**	dT

* Pode ser aplicado desde o nascimento.
** Reforço a cada dez anos, por toda a vida.
BCG: vacina contra a tuberculose.
DPT: vacina tríplice contra a difteria, a coqueluche e o tétano.
dT: vacina dupla, tipo adulto, contra a difteria e o tétano.

IMPRESSÃO OFICIAL DO ESTADO



SECRETARIA DE ESTADO DA SAÚDE
PROGRAMA NACIONAL DE IMUNIZAÇÕES

CADERNETA DE VACINAÇÕES

NOME: *Jatiana Pagnini Delapied*
DATA DO NASCIMENTO: *25 / 08 / 85*
NOME DOS PAIS: *Cláudio Delapied*
e. Jânia Regina Pagnini
ENDEREÇO: *Rua ...*

**AUM Student Health Services
Immunization Record**

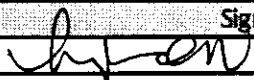
Patient Name: TATIANA DELAPEDRA

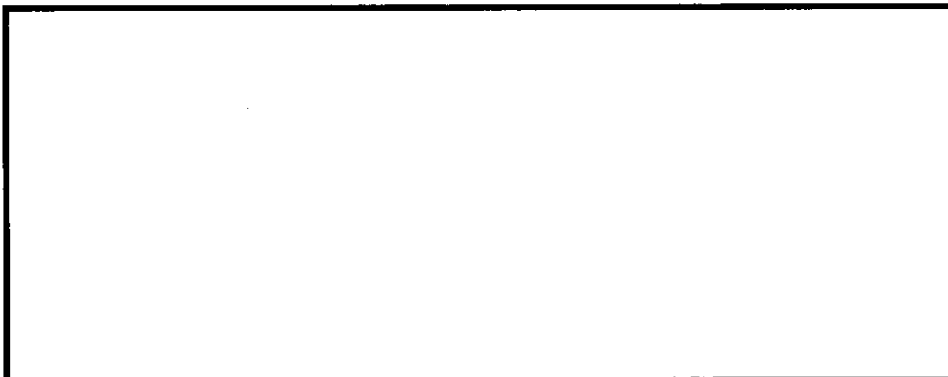
Birthdate: 08/25/1985

Allergies/Medical Alert:

Immunization	Date	Site	Dose	MFR	Comments	V.I.S.	Initials
Tdap	10/16/20	LD	0.5cc	GSK			AM
Td Booster							
MMR							
HEP A							
HEP B							
Other							

Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
	10/16/20			SP	C5735AA	(L) Forearm	AM

Initials	Signature	Initials	Signature
AM			



STAMP ABOVE

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Tatiana Delgadina
DATE OF BIRTH 08/25/85
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 Tatiana Delgadina DATE 10/16/2020

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.