



TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Lambert

FIRST NAME: Stephanie

TSCC ID #: A02097634

TETANUS, DIPHTHERIA, & PERTUSSIS (TDAP) VACCINATION - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

A TDAP BOOSTER IS REQUIRED EVERY 10 YEARS AFTER INITIAL VACCINE.

DATE OF ORIGINAL TDAP VACCINATION: _____

DATE OF MOST RECENT BOOSTER: 11/13/20

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Amy Morris RN

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

Provider:

Please place office stamp
here if not for
mailing only
**AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
P.O. BOX 244023
MONTGOMERY, AL 36124-4023**

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**AUM Student Health Services
Immunization Record**

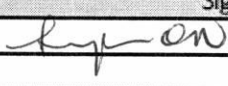
Patient Name: STEPHANIE LAMBERT

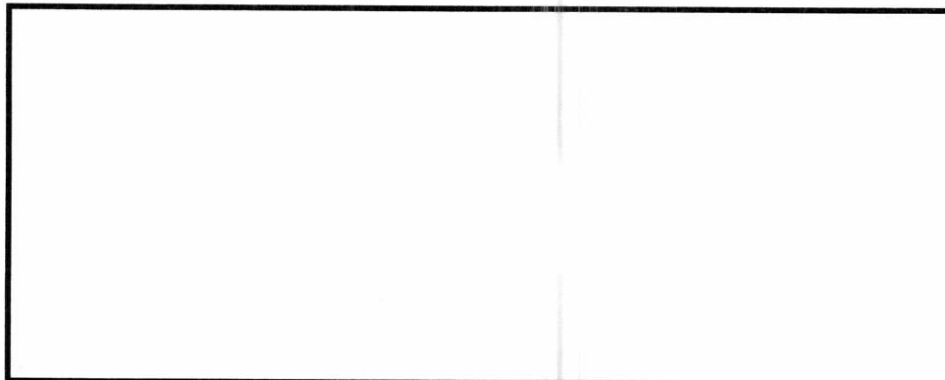
Birthdate: 02/12/1987

Allergies/Medical Alert:

Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
Tdap	11/12/2000	LD	0.5 cc	LOT: 4F99G 08/19/22			SLM
Td Booster				NDC 58160-042-43 Tetanus Toxoid Reduced Diphtheria Tetanus and Acellular Pertussis Vaccine, Adsorbed BOOSTRIX	0.5 mL		
MMR				Mfg by GlaxoSmithKline Biologicals	496018		
HEP A							
HEP B							
Other							

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

Initials	Signature	Initials	Signature
SLM			



STAMP ABOVE

Patient Information	Specimen Information	Client Information
LAMBERT, STEPHANIE DOB: 02/12/1987 AGE: 33 Gender: F Fasting: U Phone: NG Patient ID: NG	Specimen: AL950147W Requisition: 2908631 Collected: 11/12/2020 / 10:25 CST Received: 11/12/2020 / 22:59 CST Reported: 11/19/2020 / 11:11 CST	Client #: 49100638 QATL0000 TUCK, PAMELA P AUM NURSING CARE CENTER 7461 EAST DRIVE #102 MONTGOMERY, AL 36117

Test Name	In Range	Out Of Range	Reference Range	Lab
MMR (IGG) PANEL (MEASLES, MUMPS, RUBELLA)				
MEASLES ANTIBODY (IGG)	>300.00		AU/mL	AT
AU/mL	Interpretation			
<13.50	Negative			
13.50-16.49	Equivocal			
>16.49	Positive			

A positive result indicates that the patient has antibody to measles virus. It does not differentiate between an active or past infection. The clinical diagnosis must be interpreted in conjunction with clinical signs and symptoms of the patient.

MUMPS VIRUS				
ANTIBODY (IGG)	291.00		AU/mL	AT
AU/mL	Interpretation			
<9.00	Negative			
9.00-10.99	Equivocal			
>10.99	Positive			

A positive result indicates that the patient has antibody to mumps virus. It does not differentiate between an active or past infection. The clinical diagnosis must be interpreted in conjunction with clinical signs and symptoms of the patient.

RUBELLA IMMUNE STATUS				
RUBELLA ANTIBODY (IGG)	5.41		index	AT
Index	Interpretation			
<0.90	Not consistent with immunity			
0.90-0.99	Equivocal			
> or = 1.00	Consistent with immunity			

The presence of rubella IgG antibody suggests immunization or past or current infection with rubella virus.

HEPATITIS B SURFACE AB				
IMMUNITY, QN	<5 L	> OR = 10 mIU/mL		AT

Patient does not have immunity to hepatitis B virus.

For additional information, please refer to
<http://education.questdiagnostics.com/fag/FAQ105>
 (This link is being provided for informational/educational purposes only).

VARICELLA ZOSTER VIRUS				
ANTIBODY (IGG)	1583.00		index	AT
Index	Interpretation			
<135.00	Negative - Antibody not detected			
135.00 - 164.99	Equivocal			
> or = 165.00	Positive - Antibody detected			

Patient Information	Specimen Information	Client Information
LAMBERT, STEPHANIE DOB: 02/12/1987 AGE: 33 Gender: F Fasting: U Patient ID: NG	Specimen: AL950147W Collected: 11/12/2020 / 10:25 CST Received: 11/12/2020 / 22:59 CST Reported: 11/19/2020 / 11:11 CST	Client #: 49100638 TUCK, PAMELA P

Test Name	In Range	Out Of Range	Reference Range	Lab
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A positive result indicates that the patient has antibody to VZV but does not differentiate between an active or past infection. The clinical diagnosis must be interpreted in conjunction with the clinical signs and symptoms of the patient. This assay reliably measures immunity due to previous infection but may not be sensitive enough to detect antibodies induced by vaccination. Thus, a negative result in a vaccinated individual does not necessarily indicate susceptibility to VZV infection. A more sensitive test for vaccination-induced immunity is Varicella Zoster Virus Antibody Immunity Screen, ACIF.

PERFORMING SITE:

QUEST DIAGNOSTICS, ATLANTA, 1777 MONTREAL CIRCLE, DUCKING, GA 30686 Laboratory Director: ANDREW N. V. CALABRO, MD, CLIA #1102589

LIST OF RESULTS PRINTED IN THE OUT OF RANGE COLUMN:

HEPATITIS B SURFACE AB
 IMMUNITY, QN

<5 L

> OR = 10 mIU/mL

AT

Patient does not have immunity to hepatitis B virus.

For additional information, please refer to
<http://education.questdiagnostics.com/faq/FAQ105>
 (This link is being provided for informational/
 educational purposes only).

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Stephanie Lambert

DATE OF BIRTH 02 / 12 / 87
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 Stephanie Lambert DATE 11/12/20
FORM REVIEWED BY [Signature] DATE 11/12/20

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 IMMUNIZATION

LAST NAME: Lambert

FIRST NAME: Stephanie

TSCC ID #: A02097634

HAVE YOU COMPLETED A SERIES OF HEPATITIS B IMMUNIZATION? IF "YES" - SEE STEP 1 & IF "NO" SEE STEP 2.

HEPATITIS B TITER - TO BE COMPLETED BY YOUR HEALTHCARE PROVIDER.

STEP 1 - IF YOU HAVE COMPLETED A HEPATITIS B SERIES IN THE PAST - HAVE A TITER DRAWN AND COMPLETE THE FOLLOWING.
PLEASE NOTE THAT IF YOUR TITER IS NEGATIVE YOU MUST COMPLETE STEP 2.

DATE OF TITER: 1/19/20 POSITIVE? ☐ (anti-HBs ≥ 10 mIU/mL) NEGATIVE? ☒ (anti-HBs ≤ 10 mIU/mL) (please identify results with a $\checkmark$)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) _____

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

Provider:
AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
P.O. BOX 244023

MONTGOMERY, AL 36124-4023

IF YOUR TITER RESULTS ARE POSITIVE - YOU ARE DONE!
IF YOUR RESULTS ARE NEGATIVE - COMPLETE STEP 2 BELOW.

STEP 2 - IF YOU HAVE NOT COMPLETED A HEPATITIS B IMMUNIZATION OR IF YOU HAD A NEGATIVE TITER - A FULL 3-PART SERIES IMMUNIZATION IS REQUIRED.

1ST VACCINATION DATE: _____

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
Please place office stamp
here (if possible) for
validation purposes.

2ND VACCINATION DATE: _____
TO BE ADMINISTERED 1 MONTH AFTER 1ST DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
Please place office stamp
here (if possible) for
validation purposes.

3RD VACCINATION DATE: _____
TO BE ADMINISTERED 6 MONTHS AFTER 2ND DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
Please place office stamp
here (if possible) for
validation purposes.

AFTER COMPLETION OF THE FULL 3-PART SERIES, HAVE A TITER DRAWN FOR HEPATITIS B ANTIBODY TO DOCUMENT IMMUNITY:

DATE OF TITER: _____ POSITIVE? ☐ (anti-HBs ≥ 10 mIU/mL) NEGATIVE? ☐ (anti-HBs ≤ 10 mIU/mL) (please identify results with a $\checkmark$)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) _____

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
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MONTGOMERY, AL 36124-4023



INITIAL TUBERCULOSIS (TB) SKIN TEST

LAST NAME: _____

FIRST NAME: _____

TSCC ID #: A02097634

TUBERCULIN (TB) 2 STEP MANTOUX SKIN TEST - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

STEP 1 - TEST #1:

NAME OF PERSON ADMINISTERING: Amy Morris RN

DATE ADMINISTERED (TEST #1): 11/13/20 LOT #: CS7 35AA

EXPIRATION DATE: 7/28/22

DATE READ: 11/16/20 (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

TEST 1 RESULTS: _____ POSITIVE ☒ NEGATIVE _____ REDNESS (please identify results with a ✓)

0 mm (please provide measure in millimeters)

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Amy Morris RN / J. Benton, CRNP

On the date read (48-72 hrs after it is administered), your provider will evaluate, measure, and interpret the area. Your provider will document the millimeters (e.g. 0 mm, 4 mm, 12 mm) and if the 1st TST is negative, you will return for the 2nd test in 7-21 days. If the 1st test is positive, you should see your provider for additional evaluation and treatment.

IF TEST #1 WAS NEGATIVE - WAIT 7-21 DAYS BEFORE COMPLETING STEP 2

STEP 2 - TEST #2 - 7 - 21 DAYS AFTER STEP 1

NAME OF PERSON ADMINISTERING: Jessica Havard, RMA

DATE ADMINISTERED (TEST #2): 11/20/20 LOT #: CS7 35AA

EXPIRATION DATE: 07/28/2022

DATE READ: _____ (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

TEST 2 RESULTS: _____ POSITIVE _____ NEGATIVE _____ REDNESS (please identify results with a ✓)

_____ mm (please provide measure in millimeters)

PHYSICIAN/NURSE PRACTITIONER SIGNATURE J. Benton, CRNP

Provider:
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On the date read (48-72 hrs after TEST #2), your provider will evaluate, measure, and interpret the TST. Document the millimeters (e.g. 0 mm, 4 mm, 12 mm). If the 2nd TST is negative - you are done!

On the date read (48-72 hrs after TEST #2), your provider will evaluate, measure, and interpret the TST. Document the millimeters (e.g. 0 mm, 4 mm, 12 mm). If the 2nd TST is positive, you should see your provider for additional information & treatment.

IMPORTANT NOTE:

If a TB skin test cannot be performed due to past + test or BCG vaccination:

- 1) Your provider will likely order a chest x-ray and you will provide the program with a Radiologist's report - OR
- 2) Your provider (on provider letterhead) can document that you are free from TB and do not need a 2-step TB test or chest x-ray

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MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Lambert

FIRST NAME: Stephanie

TSCC ID #: A02097634

MEASLES/MUMPS/RUBELLA (MMR) TITER - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

HAVE YOU RECEIVED YOUR MMR IMMUNIZATION IN THE PAST? IF "YES" - SEE STEP 1 & IF "NO" SEE STEP 2.

STEP 1 - IF YOU HAVE COMPLETED AN MMR IMMUNIZATION IN THE PAST - HAVE A TITER DRAWN - AND HAVE YOUR PROVIDER COMPLETE THE FOLLOWING. IF ANY RESULTS ARE NEGATIVE - SEE STEP 2 - RE-VACCINATION IS REQUIRED.

DATE OF MEASLES (RUBEOLA) TITER: 11/18/20 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ☒)

DATE OF MUMPS TITER: 11/18/20 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ☒)

DATE OF RUBELLA (MEASLES) TITER: 11/19/20 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.7 AI) (please identify results with a ☒)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) Amy Morris RN

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

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

IF YOUR TITER RESULTS ARE POSITIVE, YOU ARE DONE!
IF TITER RESULTS ARE NEGATIVE OR IF YOU HAVE NEVER BEEN VACCINATED - COMPLETE STEP 2 BELOW.

MEASLES, MUMPS, RUBELLA (MMR) VACCINATION

STEP 2 - IF YOU HAVE NOT HAD AN MMR IMMUNIZATION OR IF YOU HAVE A NEGATIVE TITER - IMMUNIZATION IS REQUIRED. A HEALTHCARE PROVIDER MAY RECOMMEND A BOOSTER. IF A BOOSTER IS PERFORMED COMPLETE DOSE #1 LINE ITEM.

DOSE # 1 MEASLES (RUBEOLA) DATE: _____ DOSE # 2 MEASLES (RUBEOLA) DATE: _____

DOSE # 1 MUMPS DATE: _____ DOSE # 2 MUMPS DATE: _____

DOSE # 1 RUBELLA (MEASLES) DATE: _____ DOSE # 2 RUBELLA (MEASLES) DATE: _____

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) _____

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

Provider:
Please place office stamp
here (if possible) for
validation purposes.

AFTER COMPLETION OF STEP 2 (2-DOSE SERIES) OR BOOSTER, HAVE A TITER DRAWN FOR EACH VACCINATION RECEIVED IN STEP 2 TO DOCUMENT IMMUNITY:

DATE OF MEASLES TITER: _____ POSITIVE? ☐ NEGATIVE? ☐ (please identify results with a ☒)

DATE OF MUMPS TITER: _____ POSITIVE? ☐ NEGATIVE? ☐ (please identify results with a ☒)

DATE OF RUBELLA TITER: _____ POSITIVE? ☐ NEGATIVE? ☐ (please identify results with a ☒)

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT) _____

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

ALABAMA UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
P.O. BOX 244053
MONTGOMERY, AL 36124-4053



INFLUENZA (FLU) IMMUNIZATION

LAST NAME: _____

FIRST NAME: _____

TSCC ID #: A02097634

SEASONAL INFLUENZA (FLU SHOT) VACCINATION - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE

FLU SEASON TYPICALLY BEGINS MID-SEPTEMBER
VACCINATIONS ARE NOT AVAILABLE BEFORE THIS TIME

DATE ADMINISTERED: _____ MANUFACTURER: _____ LOT #: _____ EXPIRATION DATE: _____

SITE OF INJECTION: _____ LEFT DELTOID _____ RIGHT DELTOID (please identify location of injection with a ✓)

PROVIDER - PLEASE PRINT THE FOLLOWING INFORMATION:

NAME OF PERSON ADMINISTERING: _____ CREDENTIALS OF PERSON ADMINISTERING: _____

SIGNATURE OF PERSON ADMINISTERING: _____

NAME OF OFFICE OR FACILITY: _____ PHONE #: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

Provider:
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STUDENT HEALTH CENTER
AUBURN UNIVERSITY MONTGOMERY

**AUM Student Health Services
Immunization Record**

Patient Name: STEPHANIE LAMBERT

Birthdate: 02/12/1987

Allergies/Medical Alert:

Immunization	Date	Site	Dose	MFR	Comments	V.I. S.	Initials
Tdap							
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
	11/13/20	11/16/20	Qmm	SP	05725AA	(L) Forearm	JH
	11/24/20	11/23/20	Qmm	SP	C5735AA	(L) Forearm	AM

Initials	Signature	Initials	Signature
JH	Jaymical Howard		
AM	Stephanie Lambert		

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P.O. BOX 244023
MONTGOMERY, AL 36124-4023**

STAMP ABOVE

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PO BOX 24023
STUDENT HEALTH CENTER
UNIVERSITY OF MONTGOMERY