

ADOLESCENT & ADULT IMMUNIZATION RECORD

Clinic: _____

Name: Lambert, Stephanie

Date of Birth: 02/12/1987 Record #: _____

Allergies: NVMA Reactions: _____

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

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					Tdap					0.5cc		IM	
Hep B	12	02	2018									IM	
Hep B												IM	
Hep B												IM	
Hep B (booster if needed)												IM	
MMR Rubella Rubeola										0.5cc		SQ	
MMR Rubella Rubeola										0.5cc		SQ	
Varicella										0.5cc		SQ	
Varicella										0.5cc		SQ	
IPV										0.5cc		SQ	
IPV										0.5cc		SQ	
IPV										0.5cc		SQ	
IPV										0.5cc		SQ	
PPV23										0.5cc		IM	
PPV23										0.5cc		IM	
Hepatitis A												IM	
Hepatitis A												IM	
HPV										0.5cc		IM	
HPV										0.5cc		IM	
HPV										0.5cc		IM	
Influenza										0.5cc		IM	
Influenza										0.5cc		IM	
Influenza										0.5cc		IM	
MCV4												IM	
MPSV4												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 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: 11/19/20 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:
Please place office stamp
here (if possible) for
validation purposes.
**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.

VACCINATION DATE: 12/02/2020

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: [Signature]

Provider:
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STUDENT HEALTH CENTER
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P.O. BOX 244023**

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: MONTGOMERY, AL 36124-4023

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VACCINATION DATE: _____
ADMINISTERED 1 MONTH AFTER 1ST DOSE

VACCINATION DATE: _____
ADMINISTERED 6 MONTHS AFTER 2ND DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
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here (if possible) for
validation purposes.

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

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 _____