

ADOLESCENT & ADULT IMMUNIZATION RECORD

Clinic: _____

Name: Elasia Pearson

Date of Birth: 12/22/98 Record #: _____

Allergies: NKMA 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	11	30	20		Hep B			GSK		1.0	LD	IM	
Hep B					Hep B							IM	
Hep B					Hep B							IM	
Hep B (booster if needed)					Hep B							IM	
MMR Rubella Rubeola					MMR							SQ	
MMR Rubella Rubeola					MMR							SQ	
Varicella	11	30	20		Var							LA SQ	AM
Varicella					Var					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
PPV23					PPV					0.5cc		IM	
PPV23					PPV					0.5cc		IM	
Hepatitis A					Hep A							IM	
Hepatitis A					Hep A							IM	
HPV					HPV					0.5cc		IM	
HPV					HPV					0.5cc		IM	
HPV					HPV					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
Influenza					Flu					0.5cc		IM	
MCV4					Mening							IM	
MPSV4					Mening							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: _____

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Elasia Pearson
DATE OF BIRTH 12 / 22 / 98
month day year
22

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 Elasia Pearson DATE 11/30/20

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.

ADULT IMMUNIZATION RECORD

Allergies:

Reactions:

Name: PEARSON, ELASIA MONAE
 DOB: 12/22/1998
 CHR#: 261019839
 Date of Service: 11/16/2020

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)	DTAP	03/10/99	2 m	0.5					
	DTAP	05/11/99	4 m	0.5					
	DTAP	07/15/99	6 m	0.5					
	DTAP	05/30/01	2 y	0.5					
	DTAP	05/18/04	5 y	0.5					
	TDAP	09/21/10	11 y	0.5					
Hepatitis A (e.g., HepA, HepA-HepB)	HEP A	08/18/14	15 y	0.5					OUTSIDE CLINIC
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	HEP B UNS	12/24/98	0 m	0.5					OUTSIDE CLINIC
	HEP B ADOL/PED	03/10/99	2 m	0.5					
	HEP B ADOL/PED	07/15/99	6 m	0.5					
	HEP B UNS	12/22/99	12 m	0.5					
Human Papillomavirus (e.g., HPV)	HPV (GARDASIL)	09/21/10	11 y	0.5					
	HPV (GARDASIL)	09/19/12	13 y	0.5					OUTSIDE CLINIC
	HPV (GARDASIL)	08/18/14	15 y	0.5					OUTSIDE CLINIC
Measles, Mumps, Rubella (MMR, MMRV)	MMR	05/30/01	2 y	0.5					
	MMR	05/18/04	5 y	0.5					
Meningococcal (MCV4, MPSV4)	MCV4P (MENACTRA)	09/21/10	11 y	0.5					
Pneumococcal (e.g. PCV, PPV)	PCV7	05/30/01	2 y	0.5					
	PCV7	08/15/01	2 y	0.5					
	PCV7	09/24/01	2 y	0.5					
Polio (e.g., IPV, DTaP-HepB-Hib)	OPV	03/11/99	2 m	0.5	PO				
	OPV	05/11/99	4 m	0.5	PO				
	OPV	07/15/99	6 m	0.5					
	IPV	05/18/04	5 y	0.5					
Varicella (Var, MMRV)	VARICELLA	05/30/01	2 y	0.5					
	VARICELLA	09/21/10	11 y	0.5					
Influenza (e.g., TIV, LAIV)									
Zoster									
Other	HIB (HBOC)	03/10/99	2 m	0.5					
	HIB (HBOC)	05/11/99	4 m	0.5					
	HIB (HBOC)	07/15/99	6 m	0.5					
	HIB (HBOC)	05/30/01	2 y	0.5					

CHR- 8A

ELMORE CO HLTH DEPT
 6501 US HWY 231 NORTH

 WETUMPKA, AL36092-0006
 334 5671171

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

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Elasia Pearson

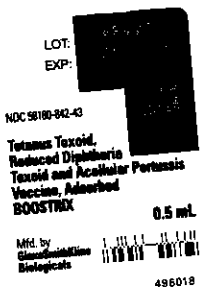
DATE OF BIRTH 12 / 22 / 1998
month day year

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 Elasia Pearson DATE Nov 11, 2020

FORM REVIEWED BY R. J. EN 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.



Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

Technical content reviewed by the Centers for Disease Control and Prevention

www.immunize.org/catg.d/p4065.pdf • Item #P4065 (4/18)

Patient Information	Specimen Information	Client Information
PEARSON, ELASIA DOB: 12/22/1998 AGE: 21 Gender: F Fasting: U Phone: NG Patient ID: NG	Specimen: AL254213X Requisition: 2908655 Collected: 11/20/2020 / 10:20 CST Received: 11/20/2020 / 23:54 CST Reported: 11/21/2020 / 15:18 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										
<table border="0" style="width: 100%;"> <tr> <td style="width: 30%;">AU/mL</td> <td style="width: 70%;">Interpretation</td> </tr> <tr> <td>-----</td> <td>-----</td> </tr> <tr> <td><13.50</td> <td>Negative</td> </tr> <tr> <td>13.50-16.49</td> <td>Equivocal</td> </tr> <tr> <td>>16.49</td> <td>Positive</td> </tr> </table>				AU/mL	Interpretation	-----	-----	<13.50	Negative	13.50-16.49	Equivocal	>16.49	Positive
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)	232.00	AU/mL	AT										
<table border="0" style="width: 100%;"> <tr> <td style="width: 30%;">AU/mL</td> <td style="width: 70%;">Interpretation</td> </tr> <tr> <td>-----</td> <td>-----</td> </tr> <tr> <td><9.00</td> <td>Negative</td> </tr> <tr> <td>9.00-10.99</td> <td>Equivocal</td> </tr> <tr> <td>>10.99</td> <td>Positive</td> </tr> </table>				AU/mL	Interpretation	-----	-----	<9.00	Negative	9.00-10.99	Equivocal	>10.99	Positive
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			AT										
RUBELLA ANTIBODY (IGG)	6.35	index											
<table border="0" style="width: 100%;"> <tr> <td style="width: 30%;">Index</td> <td style="width: 70%;">Interpretation</td> </tr> <tr> <td>-----</td> <td>-----</td> </tr> <tr> <td><0.90</td> <td>Not consistent with Immunity</td> </tr> <tr> <td>0.90-0.99</td> <td>Equivocal</td> </tr> <tr> <td>> or = 1.00</td> <td>Consistent with Immunity</td> </tr> </table>				Index	Interpretation	-----	-----	<0.90	Not consistent with Immunity	0.90-0.99	Equivocal	> or = 1.00	Consistent with Immunity
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.

VARICELLA ZOSTER VIRUS ANTIBODY (IGG)			AT										
	<135.00 L	index											
<table border="0" style="width: 100%;"> <tr> <td style="width: 30%;">Index</td> <td style="width: 70%;">Interpretation</td> </tr> <tr> <td>-----</td> <td>-----</td> </tr> <tr> <td><135.00</td> <td>Negative - Antibody not detected</td> </tr> <tr> <td>135.00 - 164.99</td> <td>Equivocal</td> </tr> <tr> <td>> or = 165.00</td> <td>Positive - Antibody detected</td> </tr> </table>				Index	Interpretation	-----	-----	<135.00	Negative - Antibody not detected	135.00 - 164.99	Equivocal	> or = 165.00	Positive - Antibody detected
Index	Interpretation												
-----	-----												
<135.00	Negative - Antibody not detected												
135.00 - 164.99	Equivocal												
> or = 165.00	Positive - Antibody detected												

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

Patient Information	Specimen Information	Client Information
PEARSON, ELASIA DOB: 12/22/1998 AGE: 21 Gender: F Fasting: U Patient ID: NG	Specimen: AL254213X Collected: 11/20/2020 / 10:20 CST Received: 11/20/2020 / 23:54 CST Reported: 11/21/2020 / 15:18 CST	Client #: 49100638 TUCK, PAMELA P

Test Name	In Range	Out Of Range	Reference Range	Lab
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.				

PENDING TESTS:

HEPATITIS B SURFACE AB IMMUNITY, QN

PERFORMING SITE:

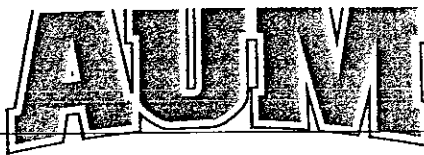
AT QUEST DIAGNOSTICS-ATLANTA, 1777 MONTREAL CIRCLE, TUCKER, GA 30084-6802 Laboratory Director: ANDREW N YOUNG, MD, PHD, CLIA: 11D0255931

LIST OF RESULTS PRINTED IN THE OUT OF RANGE COLUMN:
VARICELLA ZOSTER VIRUS
ANTIBODY (IGG)

Index	Interpretation	<135.00 L	index
<135.00	Negative - Antibody not detected		
135.00 - 164.99	Equivocal		
> or = 165.00	Positive - Antibody detected		

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.

AT



**WARHAWK
HEALTH SERVICES**

Vaccine Consent and Administration Record

Name: Elasia Pearson DOB: 12/22/1998 Phone: 334 430 5306

Mailing Address: 891 Nobles Rd City: Wetumpka ST: AL Zip: 36092

Insurance Company: _____ Subscriber name: _____ DOB: _____

Insurance Contract Number: _____ Group number: _____

Screening Questions: Yes No Don't Know

1) Are you sick today? (cold, fever, acute illness) ☐ ☒ ☐

2) Do you have allergies to any foods, medications or latex? ☐ ☒ ☐

(For example: eggs, gentamycin gelatin, food, neomycin, thimerosal, or vaccinations)
List _____

3) Have you had any serious reactions from a vaccine? ☐ ☒ ☐

4) Have you been diagnosed with Guillain-Barre syndrome? ☐ ☒ ☐

Consent for Services: I have been provided with the Vaccine Information Sheet corresponding to the vaccine that I am receiving. I have read or have had explained the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or the person named above for whom I am authorized to make this request,

Signature Elasia Pearson

Date Nov 20, 2020

Administration Date Nov 20, 2020 Route: IM LD or RD Volume: 0.5cc

Administrator [Signature] VIS Date 08/15/2019

Manufacturer: GSK Fluarix® Quadrivalent Lot # 9A235 Expires 06/30/2021

Temp: _____

LOT:
EXP:

NDC 58180-085-41

Influenza
Vaccine
FLUARIX QUADRIVALENT
2020/2021 Formula

Mfd by
Chondria
Biologics

501732