



Vaccine Forecast for : PEARSON, ELASIA MONAE

As of: 11/16/2020

DOB: 12/22/1998

Age: 21 Yrs 10 Mo 24
days

<u>Given Vaccine</u>	<u>Evaluated Vaccine</u>	<u>Vaccination Date</u>	<u>Evaluation</u>	<u>Invalid Reason</u>
DTAP UNS	DTAP UNS	03/10/1999	Valid	
DTAP UNS	DTAP UNS	05/11/1999	Valid	
DTAP UNS	DTAP UNS	07/15/1999	Valid	
DTAP UNS	DTAP UNS	05/30/2001	Valid	
DTAP UNS	DTAP UNS	05/18/2004	Valid	
HEP A PED/ADOL 2 DOSE	HEP A PED/ADOL 2 DOSE	08/18/2014	Valid	
HEP B ADOL/PED	HEP B ADOL/PED	03/10/1999	Valid	
HEP B ADOL/PED	HEP B ADOL/PED	07/15/1999	Valid	
HEP B UNS	HEP B UNS	12/24/1998	Valid	
HEP B UNS	HEP B UNS	12/22/1999	Accepted	Extra Dose
HIB (HBOC)	HIB (HBOC)	03/10/1999	Valid	
HIB (HBOC)	HIB (HBOC)	05/11/1999	Valid	
HIB (HBOC)	HIB (HBOC)	07/15/1999	Valid	
HIB (HBOC)	HIB (HBOC)	05/30/2001	Valid	
HPV (GARDASIL)	HPV (GARDASIL)	09/21/2010	Valid	
HPV (GARDASIL)	HPV (GARDASIL)	09/19/2012	Valid	
HPV (GARDASIL)	HPV (GARDASIL)	08/18/2014	Valid	
IPV	IPV	05/18/2004	Valid	
MCV4P (MENACTRA)	MCV4P (MENACTRA)	09/21/2010	Valid	
MMR	MMR	05/30/2001	Valid	
MMR	MMR	05/18/2004	Valid	
OPV	OPV	03/11/1999	Valid	
OPV	OPV	05/11/1999	Valid	
OPV	OPV	07/15/1999	Valid	
PCV7	PCV7	05/30/2001	Valid	
PCV7	PCV7	08/15/2001	Valid	
PCV7	PCV7	09/24/2001	Accepted	Extra Dose
TDAP	TDAP	09/21/2010	Valid	
VARICELLA	VARICELLA	05/30/2001	Valid	
VARICELLA	VARICELLA	09/21/2010	Valid	



Vaccine Forecast for : PEARSON, ELASIA MONAE

Recommended Vaccines:			Not Recommended Vaccines:	
Vaccine	Dose Number	Date Needed	Vaccine	Reason
HepA	2	Due Now	HPV	Series Complete
INFLUENZA	1	Due Now	HepB	Series Complete
Td (Adult), Adsorbed		Due Now	Hib	Series Complete
PneumoPPV	1	12/22/2063	MMR	Series Complete
Men B	1	Provider Discretion	Polio	Series Complete
Meningococcal		Conditional High Risk	Varicella	Series Complete
Pneumococcal Conjugate		Conditional High Risk	Rotavirus	Too Old

*This information, based on ACIP recommendations, is only a guide and should not be used exclusively to determine your patients' vaccination needs.



INFLUENZA (FLU) IMMUNIZATION

LAST NAME: Pearson

FIRST NAME: Elasia

TSCC ID #: _____

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: 11/20/20 MANUFACTURER: GSK LOT #: 9A235 EXPIRATION DATE: 6/30/21

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

PROVIDER - PLEASE PRINT THE FOLLOWING INFORMATION:

NAME OF PERSON ADMINISTERING: Amy Morris CREDENTIALS OF PERSON ADMINISTERING: RN-BC, CTH

SIGNATURE OF PERSON ADMINISTERING: [Signature] RN

NAME OF OFFICE OR FACILITY: _____ PHONE #: 334-244-3281

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

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



VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Pearson

FIRST NAME: Elasia

TSCC ID #: _____

VARICELLA/CHICKEN POX IMMUNIZATION - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

HAVE YOU RECEIVED YOUR VARICELLA/CHICKEN POX IMMUNIZATION? IF "YES" - SEE STEP 1 & IF "NO" SEE STEP 2.

STEP 1 - IF YOU HAVE PREVIOUSLY COMPLETED A VARICELLA/CHICKEN POX IMMUNIZATION OR HAVE HAD THE CHICKEN POX - HAVE A TITER DRAWN AND HAVE YOUR PROVIDER COMPLETE THE FOLLOWING. IF RESULTS ARE NEGATIVE - SEE STEP 2 - RE-IMMUNIZATION IS REQUIRED.

DATE OF VARICELLA TITER: 11/20/20 POSITIVE? _____ (≥ 1.1 AI) NEGATIVE? ☒ (≤ 0.8 AI) (please identify results with a $\checkmark$)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Amy Morris RN

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IF YOUR TITER RESULTS ARE POSITIVE - YOU ARE DONE!

IF YOUR RESULTS ARE NEGATIVE - COMPLETE STEP 2 BELOW.

STEP 2 - IF YOU HAVE NOT HAD A VARICELLA/CHICKEN POX VACCINATION OR A NEGATIVE TITER RESULT - VARICELLA IMMUNIZATION OR BOOSTER IS REQUIRED. A HEALTHCARE PROVIDER MAY RECOMMEND A BOOSTER. IF A BOOSTER IS PERFORMED COMPLETE VACCINATION #1 ONLY.

VARICELLA/CHICKEN POX VACCINE

DATE OF VARICELLA VACCINE #1: 11/30/20

DATE OF VARICELLA VACCINE #2: 12/1/20

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE Amy Morris

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AFTER COMPLETION OF 2-PART SERIES OR BOOSTER, HAVE A TITER DRAWN FOR VARICELLA ANTIBODY TO DOCUMENT IMMUNITY:

DATE OF TITER: _____ POSITIVE? _____ NEGATIVE? _____ (please identify results with a $\checkmark$)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____



TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: Pearson

FIRST NAME: Elasia

TSCC ID #: _____

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: 9/21/10

DATE OF MOST RECENT BOOSTER: 11/20/20

PHYSICIAN/NURSE PRACTITIONER NAME & CREDENTIALS (PLEASE PRINT)

Ryan RN Amy Morris RN-BC

PHYSICIAN/NURSE PRACTITIONER SIGNATURE

Ryan

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MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Pearson FIRST NAME: Elasia TSSC ID #: _____

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

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 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:
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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 _____



INITIAL TUBERCULOSIS (TB) SKIN TEST

LAST NAME: Pearson

FIRST NAME: Elasia

TSCC ID #: _____

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): 11/20/20 LOT #: C5735AA

EXPIRATION DATE: 7/28/22

DATE READ: 11/23/20 (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 [Signature] RN-BC

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: Amy Morris RN-BC

DATE ADMINISTERED (TEST #2): 11/30/20 LOT #: C5735AA

EXPIRATION DATE: 7/28/22

DATE READ: 12/2/20 (MUST BE WITHIN 48-72 HRS AFTER DATE ADMINISTERED)

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

0 mm (please provide measure in millimeters)

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature] RN

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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



HEPATITIS B IMMUNIZATION

LAST NAME: Pearson

FIRST NAME: Elasia

TSCC ID #: _____

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: 11/20/20 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) Amy Morris RN-BC

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

Provider:
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validation purposes.

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: 11/30/20

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: _____

Provider:
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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 _____