



Alabama Adult Immunization Record

Patient Name: OWENS, LAUREN C

Date of Birth: 02/13/1992

Chart No.:

BUTLER CO HLTH DEPT - GREENVILLE

350 AIRPORT RD

GREENVILLE, AL 36037-8822

334 3823154

Vaccine	Vaccine Given	Date Given	Physician or Clinic
Hepatitis B (HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)			
Diphtheria, Tetanus, Pertussis (DTaP, DTaP-Hib, DTaP-HepB-IPV, DT, Tdap, Td, DTaP-Hib-IPV)	DTP	04/13/92	OUTSIDE CLINIC
	DTP	06/15/92	OUTSIDE CLINIC
	DTP	08/17/92	OUTSIDE CLINIC
	DTP	07/01/93	OUTSIDE CLINIC
	DTAP UNS	07/30/97	OUTSIDE CLINIC
	TDAP	07/31/07	OUTSIDE CLINIC
Polio (IPV, DTaP-HepB-Hib, DTaP-Hib-IPV)	OPV	04/13/92	OUTSIDE CLINIC
	OPV	06/15/92	OUTSIDE CLINIC
	OPV	07/01/93	OUTSIDE CLINIC
	OPV	07/30/97	OUTSIDE CLINIC
Measles, Mumps, Rubella (MMR, MMRV)	MMR	07/01/93	OUTSIDE CLINIC
	MMR	07/30/97	OUTSIDE CLINIC
Varicella (Var, MMRV)			
Influenza (TIV, LAIV)	INFLUENZA UNS	12/08/03	OUTSIDE CLINIC
	IIV3 SEASONAL	10/10/14	OUTSIDE CLINIC
Other	HIB (HBOC)	04/13/92	OUTSIDE CLINIC
	HIB (HBOC)	06/15/92	OUTSIDE CLINIC
	HIB (HBOC)	08/17/92	OUTSIDE CLINIC
	HIB (HBOC)	07/01/93	OUTSIDE CLINIC
	HPV (GARDASIL)	09/13/07	OUTSIDE CLINIC
	MCV4P (MENACTRA)	11/14/07	OUTSIDE CLINIC
	HPV (GARDASIL)	05/28/08	OUTSIDE CLINIC

ADOLESCENT & ADULT IMMUNIZATION RECORD

Clinic: _____

Name: Lauren Owens

Date of Birth: 2/13/92 Record #: _____

Allergies: _____ 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 EXP
	Mo	Day	Yr		Type	Mo	Yr						
Td					Td					0.5cc		IM	NDC 58160-842-43
Td					Td					0.5cc		IM	Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed BOOSTRIX
Td					Td					0.5cc		IM	0.5 mL
Td					Td					0.5cc		IM	Mfd. by GlaxoSmithKline Biologicals
Tdap	11	30	20	28	Tdap					0.5cc	RD	IM	496018
Hep B	11	30	20	28	Hep B					10	LD	IM	
Hep B					Hep B							IM	
Hep B					Hep B							IM	
Hep B (booster if needed)					Hep B							IM	
MMR Rubella Rubeola					MMR					0.5cc		SQ	
MMR Rubella Rubeola					MMR					0.5cc		SQ	
Varicella					Var					0.5cc		SQ	
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	11	30	20	28	Flu					0.5cc	RD	IM	AM
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: _____

(over)

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Lauren Owens

DATE OF BIRTH 02 / 13 / 1992
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? <u>pen</u>	☒	☐	☐
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 Lauren Owens

DATE 11/30/20

FORM REVIEWED BY [Signature]

DATE 11/30/20

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.