

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Tiffany Mauer
DATE OF BIRTH 01 / 16 / 1990
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 Tiffany Mauer 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.



MEASLES, MUMPS, RUBELLA (MMR) IMMUNIZATION

LAST NAME: Macon

FIRST NAME: Tiffany

TSCC ID #: _____

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

HAVE YOU RECEIVED YOUR MMR IMMUNIZATION? 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-IMMUNIZATION IS REQUIRED.

DOSE #1

DATE OF MEASLES (RUBEOLA) TITER: 12/1/20 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ✓) POSITIVE?

DATE OF MUMPS TITER: 12/1/20 (≥ 1.1 AI) NEGATIVE? ☒ (≤ 0.8 AI) (please identify results with a ✓) POSITIVE? (≥ 1.1

DATE OF RUBELLA (MEASLES) TITER: 12/1/20 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.7 AI) (please identify results with a ✓)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

Provider:
AUBURN UNIVERSITY MONTGOMERY
Please place office stamp
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
if possible for
validation
P.O. BOX 244023
MONTGOMERY, AL 36124-4023

IF YOUR TITER RESULTS ARE POSITIVE - YOU ARE DONE!
IF TITER RESULTS ARE NEGATIVE - 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.

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 _____

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HEPATITIS B IMMUNIZATION

LAST NAME: Tiffany

FIRST NAME: Maion

TSCC ID #: _____

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

HEPATITIS B IMMUNIZATION - TO BE COMPLETED BY PHYSICIAN, NURSE PRACTITIONER, OR NURSE.

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: _____ POSITIVE? _____ (anti-HBs $\geq$ 10 mIU/mL) NEGATIVE? _____ (anti-HBs $\leq$ 10 mIU/mL) (please identify results with a ✓)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

Provider:
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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 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
12/11/06

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: h p on

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

2ND VACCINATION DATE: 11/23/07
TO BE ADMINISTERED 1 MONTH AFTER 1ST DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: h p on

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

3RD VACCINATION DATE: 11/30/20
TO BE ADMINISTERED 6 MONTHS AFTER 2ND DOSE

PHYSICIAN/NURSE PRACTITIONER SIGNATURE: h p on

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

AFTER COMPLETION OF 3-PART SERIES, HAVE A TITER DRAWN FOR HEPATITIS B SURFACE ANTIGENS (anti-HBs) TO DOCUMENT IMMUNITY:

DATE OF TITER: _____ POSITIVE? _____ (anti-HBs $\geq$ 10 mIU/mL) NEGATIVE? _____ (anti-HBs $\leq$ 10 mIU/mL) (please identify results with a ✓)

Titer in 1 month - h p on



VARICELLA (CHICKEN POX) IMMUNIZATION

LAST NAME: Morris

FIRST NAME: Tiffany

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: 12/1/20 POSITIVE? ☒ (≥ 1.1 AI) NEGATIVE? ☐ (≤ 0.8 AI) (please identify results with a ☒)

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

Provider:
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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 HAD A VARICELLA/CHICKEN POX VACCINATION OR A NEGATIVE TITER RESULT - VARICELLA IMMUNIZATION IS REQUIRED.

VARICELLA/CHICKEN POX VACCINE

DATE OF VARICELLA VACCINE #1: _____

DATE OF VARICELLA VACCINE #2: _____

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE _____

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TDAP (TETANUS, DIPHTHERIA, PERTUSSIS) IMMUNIZATION

LAST NAME: MAcon

FIRST NAME: Tiffany

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: _____

DATE OF MOST RECENT BOOSTER: 11/30/20

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

PHYSICIAN/NURSE PRACTITIONER SIGNATURE [Signature]

Provider
AUBURN UNIVERSITY MONTGOMERY
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IRMA E. MOORE HALL RM. 102
validation P.O. BOX 244023
MONTGOMERY, AL 36124-4023



INFLUENZA (FLU) IMMUNIZATION

LAST NAME: Mason FIRST NAME: Tiffany 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: 11/30/20 MANUFACTURER: GSK LOT #: NS49A 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

SIGNATURE OF PERSON ADMINISTERING: [Signature]

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

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

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

ADULT IMMUNIZATION RECORD

Allergies:
Reactions:

Name: MACON, TIFFANY S
 DOB: 01/16/1990
 Chart #:
 Date of Service: 11/30/2020

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)	DTP	03/20/90	2 m	0.5					OUTSIDE CLINIC
	DTP	05/23/90	4 m	0.5					OUTSIDE CLINIC
	DTP	07/23/90	6 m	0.5					OUTSIDE CLINIC
	DTP	09/12/91	19 m	0.5					OUTSIDE CLINIC
	DTAP	08/22/94	4 y	0.5					OUTSIDE CLINIC
	TDAP	12/11/06	16 y	0.5					OUTSIDE CLINIC
	TD	03/21/14	24 y	0.5	IM				OUTSIDE CLINIC
Hepatitis A (e.g., HepA, HepA-HepB)									
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	HEP B ADOL/PI/D	12/11/06	16 y	0.5					OUTSIDE CLINIC
	HEP B ADOL/PI/D	01/23/07	17 y	0.5					OUTSIDE CLINIC
Human Papillomavirus (e.g., HPV)									
Measles, Mumps, Rubella (MMR, MMRV)	MMR	09/12/91	19 m	0.5					OUTSIDE CLINIC
	MMR	08/22/94	4 y	0.5					OUTSIDE CLINIC
Meningococcal (MCV4, MPSV4)									
Pneumococcal (e.g., PCV, PPV)									
Polio (e.g., IPV, DTaP-HepB-Hib)	IPV	03/20/90	2 m	0.5					OUTSIDE CLINIC
	IPV	05/23/90	4 m	0.5					OUTSIDE CLINIC
	IPV	09/12/91	19 m	0.5					OUTSIDE CLINIC
	IPV	08/22/94	4 y	0.5					OUTSIDE CLINIC
Varicella (Var, MMRV)									
Influenza (e.g., TIV, LAIV)									
Zoster									
Other	HIB UNS	09/12/91	19 m	0.5					OUTSIDE CLINIC

AUM STUDENT HEALTH SERVICES
 7461 EAST DRIVE
 RM 102 MOORE HALL
 MONTGOMERY, AL 36117
 334 2443281

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