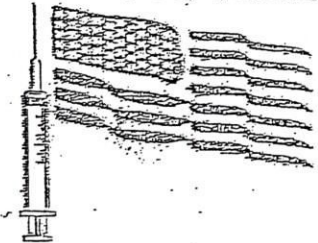


ADOLESCENT & ADULT IMMUNIZATION RECORD

CLINIC:

Protect Our Future!



Name: Carol Alford

Date of birth: 3/10/47 Record #

Allergies: Sulfa Reactions:

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

Immunize!

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					Hep B							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					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: over

***Provider Information

[illegible]

Tuberculin Test

Date Admin			Test Type		Provider*** placing the test	Provider*** reading the test	Results	Notes
Mo	Day	Yr	PPD	Time				

Titer Test Results for New Guinea Virus - 4/11/11

Titer Test Results for Non Susceptibility (IgM)

[illegible][illegible]

OTHER IMMUNIZATIONS/PROPHYLAXIS REC'D

Autres vaccinations/prophylaxies reçues

This space is provided to record immunizations/prophylaxis that are not required for entrance into any country but have been obtained by the traveler for additional health protection (immune globulin, malaria, measles, etc.).

Inscrivez dans cet espace les vaccinations ou prophylaxies non obligatoires pour l'admission dans un pays, mais qui ont été effectuées pour une protection accrue (immunoglobulines, paludisme, rougeole...).

Date	Vaccine/prophylactic drug Vaccin/médicament prophylactique	Dose	Physician's signature Signature du médecin
3.4.14	Jetanus (Idap)	0.5mL	MCND - V. Head, RN
3.4.14	MMR	0.5mL	MCND - V. Head, RN
3.4.14	Hepatitis A/B #1	1.0mL	MCND - V. Head, RN
4.11.14	Hepatitis A/B #2	1.0mL	MCND - V. Head, RN
4.11.14	Typhoid v1	0.5mL	MCND - V. Head, RN
4.11.14	IPV - (Polio)	0.5mL	MCND - V. Head, RN
9.6.14	Hepatitis A/B #3	1.0mL	MCND - V. Head, RN

CPC 731 (formerly PH 503)

Montgomery County Health Department
 Immunization Services
 1000 Mobile Blvd
 Montgomery, Alabama 36108
 (205) 442-3448
 DEPARTMENT OF HEALTH SERVICES
 CENTERS FOR DISEASE CONTROL AND PREVENTION

(County - Département)
(State - Pays)

(City - Ville)
 MONTGOMERY AL 36105
 PH: (334) 306-5027

ALT: DR. CAROL H
 SSN: R:W
 MED: SEX: F
 ADDRESS: 91 RIDGELAND FARMS ROAD
 DATE: 03/04/2014
 CHR: 511194032
 DB: 03/10/1947

INTERNATIONAL CERTIFICATE OF VACCINATION OR PROPHYLAXIS
 AS APPROVED BY
 THE WORLD HEALTH ORGANIZATION
CERTIFICAT INTERNATIONAL DE VACCINATION OU DE PROPHYLAXIE
 APPROUVÉ PAR
 L'ORGANISATION MONDIALE DE LA SANTE

MEDICAL CONTRAINDICATION TO VACCINATION Contre-indication médicale à la vaccination

This is to certify that immunization against
 Je soussigné(e) certifie que la vaccination contre

(Signature and address of physician)
 (Signature et adresse du médecin)

(Name of disease - Nom de la maladie)

for