

**AUM Student Health Services  
Immunization Record**

**Patient Name:**

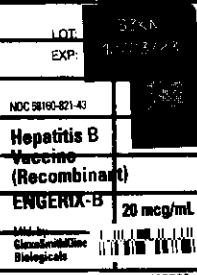
Gale Skinner

**Birthdate:**

10-15-1960

**Allergies/Medical Alert:**

| Immunization | Date   | Site     | Dose | MFR | Comments | V.I. S. | Initials |
|--------------|--------|----------|------|-----|----------|---------|----------|
| Tdap         |        |          |      |     |          |         |          |
| Td Booster   |        |          |      |     |          |         |          |
| MMR          |        |          |      |     |          |         |          |
| HEP A        |        |          |      |     |          |         |          |
| HEP B        | 3-3-22 | Left Arm |      |     |          |         | DM       |
| Other        |        |          |      |     |          |         |          |



| Tuberculin Testing<br>PPD (MANTOUX)<br>0.1 ml ID | Date Given: | Date Read: | Results: | MFR | LOT# | Comments | Initials |
|--------------------------------------------------|-------------|------------|----------|-----|------|----------|----------|
|                                                  |             |            |          |     |      |          |          |
|                                                  |             |            |          |     |      |          |          |
|                                                  |             |            |          |     |      |          |          |
|                                                  |             |            |          |     |      |          |          |

| Initials | Signature               | Initials | Signature |
|----------|-------------------------|----------|-----------|
| DM       | <i>Derrick M. Moore</i> |          |           |
|          |                         |          |           |
|          |                         |          |           |

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

**STAMP ABOVE**

# Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Gale Skinner  
DATE OF BIRTH 10 / 15 / 1960  
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?                                                                                                                                                                                                                                             | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have allergies to medications, food, a vaccine component, or latex?                                                                                                                                                                                      | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had a serious reaction after receiving a vaccination?                                                                                                                                                                                             | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 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?                                                                                           | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
| 5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?                                                                                                                                                                                     | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | <input type="checkbox"/> |
| 7. Have you had a seizure or a brain or other nervous system problem?                                                                                                                                                                                              | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 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?                                                                                                                   | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?                                                                                                                                                               | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you received any vaccinations in the past 4 weeks?                                                                                                                                                                                                        | <input type="checkbox"/>            | <input checked="" type="checkbox"/> | <input type="checkbox"/> |

FORM COMPLETED BY Gale Skinner DATE 3-3-22  
FORM REVIEWED BY Rachael Margetts DATE 3-3-22

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.