



Hepatitis A Reminder

Date: 11/28/17

Dear Ali.

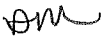
Your final Hepatitis A vaccination is due on 12/15/17.
It is important that you continue your series within the recommended schedule to obtain the maximum effect from your vaccination.

In order to achieve maximum benefits, you should receive your vaccine no later than
12/29/17.

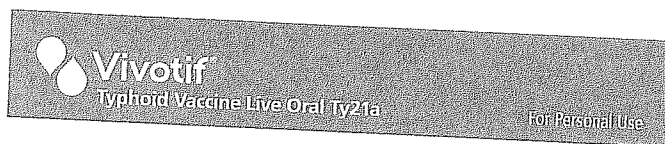
If you have received this immunization elsewhere, please submit a copy for our records.
If you wish to continue the series at the AUM Nursing Care Center, contact our clinic at 244-3281 to set up an appointment at your earliest convenience.

Thank you for allowing us to participate in the protection of your good health.

Sincerely,


Amy Morris, RN

Amy Morris, MPA, RN-BC



Remember:
Take 1 capsule every other day
for 7 days.

DAY 1	DAY 2	DAY 3	DAY 4	DAY 5	DAY 6	DAY 7
1st Capsule	Skip a day	2nd Capsule	Skip a day	3rd Capsule	Skip a day	4th Capsule
☒	☐	☐	☐	☐	☐	☐

Take on an empty stomach (at least 1 hour before or 2 hours after a meal)

Take with cold or lukewarm water

Do not take with antibiotics

Keep the capsules refrigerated (35°F-46°F)

What is Vivotif?

Vivotif (Typhoid Vaccine)

Carol Stewart, C.R.N.P.
Lic. #1-045437
Rx: 1178

AUBURN MONTGOMERY
STUDENT HEALTH CENTER
P. O. Box 244023
Montgomery, AL 36124-4023
(334) 244-3281

Ramona Lazenby, C.R.N.P.
Lic. #1-039092
Rx: 0703

Darlene Pierce, C.R.N.P.
Lic. #1-134315
RX: 3692

Maryluz Fuentes, M.D.
(334) 286-3444
DEA #BF 6451520
AL #24127

Name Ali Mitchell Date 6/15/17
Address _____

Rx

Vivotif
Disp: 4
Sig: Take as directed.

_____, M.D. or C.R.N.P.
Product Selection Permitted

Label all prescriptions

Refill: 1 2 3 5 PRN NR

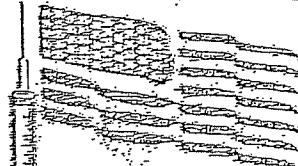
Dispense As Written

_____, M.D. or C.R.N.P.

ADOLESCENT & ADULT IMMUNIZATION RECORD

CLINIC:

Protect Our Future!



Name: Ali Mitchell

Date of birth: 7/31/1995 Record # _____

Allergies: _____

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					cc		SQ	
IPV					Polio					cc		SQ	
IPV					Polio					cc		SQ	
IPV					Polio					cc		SQ	
PPV23					PPV					0.5cc		IM	
PPV23					PPV					cc		IM	
Hepatitis A	6	15	17		Hep A	7	16	GSK	474192	0.5cc	LD	IM	AMC
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: _____