

Mims, Molly

PATIENT NAME: Mims, Molly
 DOB: 1-18-98 Chart#: 334789

White Wilson Medical Center, P.A.
 1005 Mar Watt Drive Fort Walton Beach, FL 32547

ALLERGIES:

PROBLEM LIST

DATE	PROBLEM	STATUS	DATE	SURGERY/HOSPITALIZATION

"I have read, or have had explained to me information about the diseases and the vaccines listed below...I believe I understand the benefits and risks of the vaccines cited, and ask that the vaccine(s) listed below be given to me or to the person named below for whom I am authorized to make this request."

VACCINE	Date given	Vaccine Manufacturer	Vaccine Lot Number	Site Given	Initials of Vaccine Administrator	Signature of Parent or Guardian
DTP1	3-15-95					
DTP2	5-16-95					
DTP3	7-27-95					
DTP/DTaP4	2-6-96					
DTR/DTaP5	1-21-2000	Jedene	464-31	Anterior	BB	(X) Paula E Mims
OPV/IPV1	3-15-95					
OPV/IPV2	5-16-95					
OPV/IPV3	7-27-95					
OPV/IPV4	1-21-2000	Jedene	466-396	Oral	BB	(X) Paula E Mims
MMR1	2-6-96	Merck	05483	Anterior	BB	(X) Paula E Mims
MMR2	1-21-2000					
Hib 1	3-15-95					
Hib 2	5-16-95					
Hib 3	7-27-95					
Hib 4	2-6-96					
DTaP-Acell	5/25/07	Acell	C2044AA/10/07			(X) Paula E Mims
Td						
Hep B1	1-18-95					
Hep B2	3-15-95					
Hep B3	2-6-96					
Varivax	8-23-96					
KeVnaat1	2-2-01	Jedene	472-051	Anterior	BB	(X) Paula E Mims
Menactra	5/25/07	Sanofi	07233CA/4/11/07			(X) Paula E Mims
Varivax #2	5/25/07	Merck	1501F/12/1/07			(X) Paula E Mims
Gardasil #1	5/25/07	Merck	03866/2/3/07	IA		(X) Paula E Mims
Gardasil #2	6/13/08	Merck	1978u/8-24-10	IA		(X) Paula E Mims

* Signature of Vaccine Administrator	

Student's Name Molly Mims Birthdate 1/18/95 Date 24 Jun 15

Required Immunizations

1. Tetanus-Diphtheria-Pertussis (Tdap), Adult-Type Date 05/25/07 Dosage Adacel

2. MMR Vaccine (Those born before 1957 are exempt)
(Must be one dose after 1980) Date 02/06/96 Dosage _____
Date 1/21/00 Dosage _____

3. Hepatitis B Vaccine: Initial Dose Date 01/18/95 Dosage _____
Second Dose Date 03/15/95 Dosage _____
Third Dose Date 02/06/96 Dosage _____

4. The varicella vaccine for chickenpox is required if IgG antibody levels are < 1:8 or negative . (See #1 of
Required Diagnostic Studies)

Varicella Vaccine: Initial Dose Date 08/23/96 Dosage _____
Second Dose Date 05/25/07 Dosage _____

Required Diagnostic Studies (Please attach copy of lab results.)

1. Varicella IgG Titer (Required for all students except those with history of 2 doses of varicella vaccine)
Date _____ Result _____

2. Hepatitis B Surface Antibody Titer (if Hepatitis B series is complete or no documentation is available)
Date _____ Results _____

3. MMR Titers **If no available documentation of the vaccine exists, titers for measles, mumps and rubella will be
accepted and are preferred.

Measles (Rubeola)	Date _____	Results _____
Mumps	Date _____	Results _____
Rubella	Date _____	Results _____

NOTE: Students must possess the functional ability to perform the skills and demonstrate the behaviors required of a professional nurse. These abilities include but are not limited to (a) adequate vision, such as that required to observe changes in physical conditions, to read small print on labels and reports, and to discern subtle changes in color; (b) adequate hearing, such as that required to distinguish muted sounds through a stethoscope; (c) fine motor skills and manual dexterity, such as required to handle small, delicate equipment; (d) strength to turn and assist with lifting adults, and to lift and carry children; (e) the mobility to perform skills and respond quickly in emergency situations; (f) the ability to communicate and interact effectively with others, verbally and in writing; and (g) the ability to detect odors.

*****Are there any conditions, concerns, or treatments that may affect the ability of this student to meet these program requirements? () YES () NO**

Health Care Provider's Name (Print): DR. ANDREW M. YANG
Address: 2001 E HIGHWAY 20
City, State, Zip Code: NICEVILLE, FL 32578
Phone: () 850-897-4400
850-897-0628

Date of Exam _____

Health Care Provider's Signature 