

**AUM Student Health Services
Immunization Record**

Patient Name: Yojin An

Birthdate: _____

Allergies/Medical Alert: _____

Immunization	Date	Site	Dose	MFR	Comments	Visit Date	Initials
Tdap							
Td Booster							
MMR							
HEP A							
HEP B							
Other							

	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	2/19/19	2/21/19	2mm	SP	C5563AB	(L) fore arm	AM

Initials	Signature	Initials	Signature
AM	<i>[Signature]</i>		

STAMP ABOVE