

# Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
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 type="checkbox"/> | <input checked="" 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 type="checkbox"/> | <input checked="" 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 Agnes Crosby DATE 6-20-17

FORM REVIEWED BY \_\_\_\_\_ DATE \_\_\_\_\_

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.



AUBURN  
MONTGOMERY

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## Hepatitis A Reminder

Date: 11/28/17

Dear Mrs. Crosby

Your final Hepatitis A vaccination is due on 12/20/17.

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

Jan 3, 2018.

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

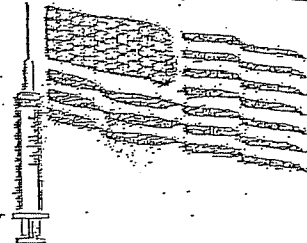
AUBURN UNIVERSITY AT MONTGOMERY  
STUDENT HEALTH SERVICES

P. O. Box 244023, Montgomery, Alabama, 36124; Telephone: 334-244-3281, Fax: 334-244-3396

# ADOLESCENT & ADULT IMMUNIZATION RECORD

CLINIC:

Protect Our Future!



Name: Agnes Crosby

Date of birth: 1/25/69 Record #

Allergies: NKA

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          |    |    |             |            |       |              | SQ    |                                               |
| IPV                       |            |     |    |                 | Polio          |    |    |             |            |       |              | SQ    |                                               |
| IPV                       |            |     |    |                 | Polio          |    |    |             |            |       |              | SQ    |                                               |
| IPV                       |            |     |    |                 | Polio          |    |    |             |            |       |              | SQ    |                                               |
| PPV23                     |            |     |    |                 | PPV            |    |    |             |            |       |              | IM    |                                               |
| PPV23                     |            |     |    |                 | PPV            |    |    |             |            |       |              | 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:

### \*\*\*Provider Information

[illegible]

## Tuberculin Test

[illegible]

### Titer Test Results for Non Susceptibility (IgM)

[illegible][illegible]