

ADULT IMMUNIZATION RECORD

Allergies:

Reactions:

Name: REDDING, ZACHARY A

DOB: 03/02/1992

Chart #:

Date of Service: 04/20/2017

Vaccine Family	Type of Vaccine (no Brand Name)	Date Given (mm/dd/yy)	Age at Adm	Dose (cc/mL)	Route & Site	Mfr.	Lot #	VIS Date	Q	Vaccinator Signature
Tetanus, Diptheria, (Pertussis) (e.g., Td, Tdap)	DTP	05/06/92	2 m	0.5						
	DTP	07/02/92	4 m	0.5						
	DTP	10/20/92	7 m	0.5						
	DTP	09/16/93	18 m	0.5						
	DTP	07/30/96	4 y	0.5						
	TD	03/22/04	12 y	0.5						
Hepatitis A (e.g., HepA, HepA-HepB)										
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	HEP B ADOL/PED	03/02/92	0 m	0.5						
	HEP B ADOL/PED	12/04/92	9 m	0.5						
	HEP B	02/23/95	2 y	0.5						
Human Papillomavirus (e.g., HPV)										
Measles, Mumps, Rubella (MMR, MMRV)	MMR	06/21/93	15 m	0.5						
	MMR	04/21/97	5 y	0.5						
Meningococcal (MCV4, MPSV4)										
Pneumococcal (e.g. PCV, PPV)										
Polio (e.g., IPV, DTaP-HepB-Hib)	OPV	05/06/92	2 m	0.5						
	OPV	07/02/92	4 m	0.5						
	OPV	09/16/93	18 m	0.5						
	OPV	04/25/97	5 y	0.5						
Varicella (Var, MMRV)										
Influenza (e.g., TIV, LAIV)										
Zoster										
Other	HIB	05/06/92	2 m	0.5						
	HIB	07/02/92	4 m	0.5						
	HIB	06/21/93	15 m	0.5						
	HIB	09/16/93	18 m	0.5						

PROFESSIONAL PEDIATRICS
4154 CARMICHAEL RD

MONTGOMERY, AL36106
334 2715959

PPD	Date	Results	PPD	Date	Results
Mantoux			Maxtoux		
Mantoux			Mantoux		
Mantoux			Mantoux		

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Zachary Redding
DATE OF BIRTH 03 / 02 / 1992
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?	☐	☒	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☒	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☒	☐
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?	☐	☒	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☒	☐
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?	☐	☒	☐
7. Have you had a seizure or a brain or other nervous system problem?	☐	☒	☐
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?	☐	☒	☐
9. For women: Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
10. Have you received any vaccinations in the past 4 weeks?	☐	☒	☐

FORM COMPLETED BY Zachary Redding DATE 06-26-17
FORM REVIEWED BY [Signature] DATE 06/26/17

Did you bring your immunization record card with you?

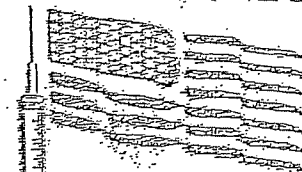
yes ☒ no ☐

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.

ADOLESCENT & ADULT IMMUNIZATION RECORD

CLINIC:

Protect Our Future!



Name: Zachary Redding

Date of birth: 3/2/1992 Record #

Allergies: PCN, cipro

Reactions: Rash/Hives

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	6	26	17	25	Tdap	2	15	SP	Adacel® NDC 49281-400-58 (L) C5216AB (R) 06 JUN 2016	0.5cc	LD	IM	AM
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					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
PPV23					PPV					0.5cc		IM	
PPV23					PPV					0.5cc		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]