

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME ALI AL BRAHIM

DATE OF BIRTH 12 / 29 / 1996
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 ALI AL BRAHIM

DATE 8/10/2017

FORM REVIEWED BY [Signature]

DATE 8/10/2017

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.

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Immunization (Vaccination) Form

To ensure the health and safety of our campus, immunizations against communicable diseases are extremely important. Vaccination against Measles, Mumps, Rubella (MMR) and Tetanus, Diphtheria and Pertussis is required of all students entering Auburn University at Montgomery. This form must be completed and is the preferred document for proof of immunizations. Take this form to a doctor or clinic to be completed. Also, upon arrival to the campus, international students will be required to report to Student Health Services to receive a Tuberculosis Skin Test. The cost of this test is \$10.00. **TB skin tests performed outside of the United States will not be accepted.**

Name ABRAHIM ALI Mubeeq AUM Student Number 500343586
 Last First Middle

Local Address _____
 Street City State Zip Code

615 540 3628 a-m-b-14170@hotmail.com 12/9/1996
 Cell Phone Number E-mail Address Date of Birth (MMDD/YYYY)

REQUIRED IMMUNIZATIONS (Vaccinations)

Tetanus, Diphtheria, Pertussis Vaccine (preferred). Students without previous documentation of a TDaP vaccine should have one dose prior to entrance based on current guidelines. A DTaP will not be accepted.

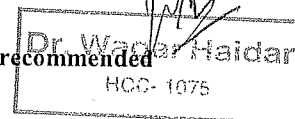
Date of Tdap vaccine: ____/____/____ (within the last 5 years).
 D M Y

Measles, Mumps, Rubella (MMR) 2 separate vaccinations of the MMR, given at least 1 month apart is required.

Auburn Montgomery University requires that all students born after 1956 must have had 2 doses of a measles containing vaccine (MMR) prior to registration. One dose must have been after 1980. Lab antibody titers (IgG) for Measles, Mumps and Rubella are acceptable. Please attach documentation to the back of the form.

Date of First Dose 8/12/1997 Date of Second Dose 13/7/2017
 D M Y D M Y

OPTIONAL IMMUNIZATIONS (These immunizations are not required by the university but are recommended by the American College Health Association.)



Hepatitis B: ____/____/____ ____/____/____ ____/____/____
 1st 2nd 3rd

Varicella (Chickenpox) Vaccine: ____/____/____ ____/____/____
 1st 2nd

Meningococcal (meningitis) Vaccine: ____/____/____ ____/____/____ (MCV4 preferred)
 1st 2nd

I certify that the above dates and vaccinations are true.

_____/_____/_____
 Signature of License Health Care professional Date License Number or Office Stamp

7mm