

**AUM NURSING CARE CENTER
IMMUNIZATION RECORD**

PATIENT NAME: megan Traffanstedt BIRTHDATE: 11-3-88

ALLERGIES/MEDICAL ALERT: _____

IMMUNIZATION	DATE	SITE	DOSE	MFR	LOT #	COMMENTS	VIS/DATE	INITIALS
DPT								
DPaT								
DT								
Td BOOSTER								
MMR								
MR								
HIB								
HEPATITS B								
OTHER								

TUBERCULIN TESTING (MANTOUX) 0.1ml ID	DATE GIVEN	DATE READ	RESULTS	MFR	LOT #	COMMENTS	INITIALS
	9/6/17			SP	CS039AA	(L) forearm	AM

INITIALS	SIGNATURE	INITIALS	SIGNATURE
AM	<i>[Signature]</i>		

**AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER
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