

**AUM Student Health Services
Immunization Record**

Patient Name: Julie Freeman

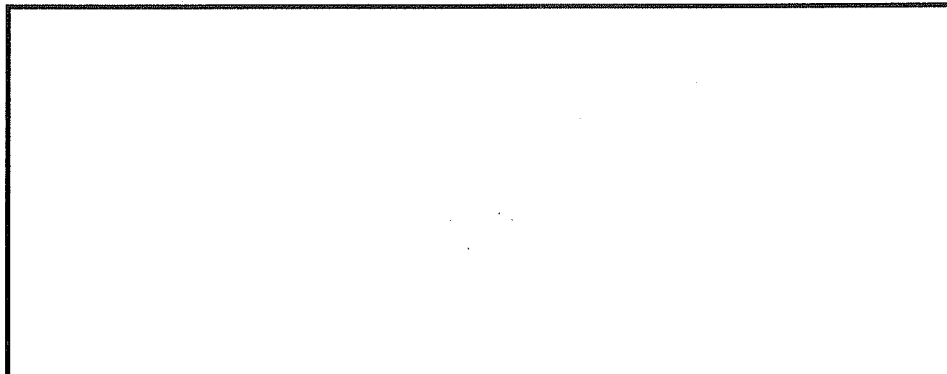
Birthdate: 4/27/1957

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	8/28/19	8/30/19	0mm	SP	CS588AA	(2) forearm	AM

Initials	Signature	Initials	Signature
AM	Ryan		



STAMP ABOVE

AUM Student Health Center

Vaccine Consent and Administration Record

Patient Information: Last Name Freeman First Name Julie Date of Birth 04/27/1957

Address: 9240 Gainswood

Phone: 334-312-2095 Primary Care Provider Dr. Jon Dailey

Screening Questions:	Yes	No	Don't Know
1) Are you sick today? (cold, fever, acute illness)	☐	☒	☐
2) Do you have allergies to any foods, medications or latex? (For example: eggs, gelatin, neomycin, thimerosal.) List <u>Demerol; Plavix Plavix Plaquenil</u>	☒	☐	☐
3) Do you take anticoagulation medicine? (Ex: warfarin, Coumadin or other blood thinners).	☐	☒	☐
4) Do you have any long-term health problems with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorders?	☐	☒	☐
5) Have you had a seizure, brain or other nervous system problem? (Ex: Guillain-Barre syndrome?)	☐	☒	☐
6) For women: Are you pregnant or nursing? Could you become pregnant in during the next month?	☐	☒	☐

Consent for Services: I have been provided with the Vaccine Information Sheet corresponding to the vaccine that I am receiving. I have read or have had explained the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or the person named above for whom I am authorized to make this request,

Signature Julie C Freeman Date 8/28/2019

Administration Date 8/28/19 Route: IM LD or RD Volume: 0.5cc

Administrator [Signature] VIS Date 08/15/2019

Manufacturer: GSK Fluarix® Quadrivalent Lot # 3L32N Expires 06/30/2020

LOT: 3L32N
EXP: 06/30/20

NDC 5818-999-41
Influenza Vaccine
FLUARIX QUADRIVALENT
2019/2020 Formula
0.5 mL
Mfd. by GlaxoSmithKline Biologicals
497180