

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME _____

DATE OF BIRTH 10 / 09 / 95
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 Cassidy Baillie DATE 6-7-17

FORM REVIEWED BY Lynn RN DATE 6/1/17

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:

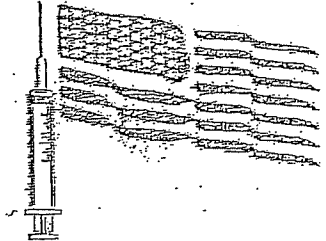
Name: Cassidy Ballie

Date of birth: 10/05/1995 Record #

Allergies: Reactions:

History of Chickenpox? YES or NO If yes, date if known:

Protect Our Future!



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					0.5cc		IM	
PPV23					PPV					1440 ELU/mL		IM	
Hepatitis A	6	1	17		Hep A	7	16	GSK		474182	LD	IM	AM
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:

Carol Stewart, C.R.N.P.
Lic. #1045437
Rx: 1178

AUBURN MONTGOMERY
STUDENT HEALTH CENTER
P. O. Box 244023
Montgomery, AL 36124-4023
(334) 244-3281

Ramona Lazenby, C.R.N.P.
Lic. #1-039092
Rx: 0703

Darlene Pierce, C.R.N.P.
Lic. #1-134315
RX: 3692

Maryluz Fuentes, M.D.
(334) 286-3444
DEA #BF 6451520
AL #24127

ORAL (TIE-foyd)

Name Cassidy Ballie Date 6/1/17
Address _____

Rx

Vivotif
Disp: 4
Sig: Take as directed.

a certain bacteria
inking contaminated
ing to areas where
Asia), who are exposed
poratory. Typhoid
body to produce its own

Label all prescriptions

Refill: 1 2 3 5 PRN NR

Product Selection Permitted

M.D. or C.R.N.P.

Dispense As Written

M.D. or C.R.N.P.

of age against typhoid fever. However, vaccination is recommended for certain groups including people traveling to areas where there is a risk of exposure to typhoid fever; people with intimate exposure (such as household contact) to someone who carries *Salmonella Typhi* (STyphi), the bacterium that causes typhoid fever; and people who work in a laboratory with STyphi.

Not everyone who takes Vivotif will be fully protected against typhoid fever. Therefore, you should continue to take precautions against typhoid fever exposure. Vivotif does not protect against other *Salmonella* species or other bacteria that cause disease of the gastrointestinal tract. Vivotif should not be used to treat infections with STyphi.

Important Safety Information

Do not take Vivotif if:

- You are allergic (hypersensitive) to any of the ingredients contained in Vivotif
- You have a poor immune system for any reason
- You have an infection with a high temperature
- You have an acute gastrointestinal illness

Tell your health care professional if you are taking or have recently taken any other medicines. This is because Vivotif can affect the way some medicines work and some medicines can affect the way Vivotif works. In particular, tell your health care professional if you are taking antibiotics or medicines to prevent malaria. Postpone taking Vivotif if persistent diarrhea or vomiting is occurring. It is essential that all 4 doses of vaccine be taken at the prescribed alternate day interval to obtain a maximal protective immune response. In clinical trials, the most common side effects observed were abdominal pain, nausea, headache, fever, diarrhea, vomiting, and skin rash.

Report any serious adverse reactions to your health care professional. You may also report an adverse reaction directly to the Vaccine Adverse Event Reporting System at 1-800-822-7967 or <http://vaers.hhs.gov>

is effect persist.

With care provider before
Before taking each
open the blister pack and

t damaged. Consult your pharmacist if the foil blister pack or
on by mouth without food, usually every other day for 4 doses or
capsule whole with cold or barely warm liquid about 1 hour before
and swallow with the liquid immediately. Do not chew, crush, or
he dosing schedule closely for the vaccine to be most effective.
lar to keep track of when to take your next dose. You should
ast 1 week before possible exposure to typhoid fever. You may
at risk for typhoid fever after 5 years. Ask your doctor or



Hepatitis A Reminder

Date: 11/28/17

Dear Cassidy.

Your final Hepatitis A vaccination is due on Dec 1, 2017.
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
Dec 15, 2017.

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