

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME Medgar Scott
DATE OF BIRTH 8/27/63
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 [Signature]

DATE 6-1-18

FORM REVIEWED BY Melody M. Hay

DATE 6/1/18

Did you bring your immunization record card with you?

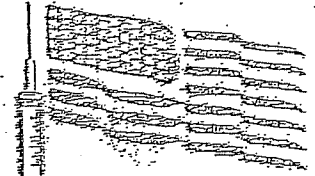
yes ☐ no ☒

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: medgar Scott

Date of birth: 8/27/63 Record #

Allergies: A

Reactions:

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

IMMUNIZE!

Vaccine	Date Admin			Age at the time	VIS Form Given			Manuf Abbr ²	Lot Number	Dose	Admin Site ²	Route	Provider Initials ² 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	11	1	17		Tdap	2	15	SP	Adacel [®] NDC 49281-400-50 (L) C5243AA (E) 26 JUL 2019	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				LOT: AC9F4 EXP: 12/14/19	0.5cc		SQ	
IPV					Polio				NDC 58160-826-43	0.5cc		SQ	
IPV					Polio				Hepatitis A Vaccine HAVRIX [®]	0.5cc		SQ	
PPV23					PPV					0.5cc		IM	
PPV23					PPV				Mfd. by GlaxoSmithKline Biologicals 1440 EL.U./mL	0.5cc		IM	
Hepatitis A	11	1	17		Hep A	7	16	GSK	474182	1.0	RD	IM	Am
Hepatitis A	6	1	18		Hep A	7	16	GSK		1	LD	IM	(MA)
HPV					HPV				LOT: AC9F4 EXP: 12/14/19			IM	
HPV					HPV				NDC 58160-826-43			IM	
HPV					HPV				Hepatitis A Vaccine HAVRIX [®]	0.5cc		IM	
Influenza					Flu				1440 EL.U./mL	0.5mL		IM	
Influenza					Flu				Mfd. by GlaxoSmithKline Biologicals			IM	
MCV4					Mening				474392			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:

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME

MEDALL Scott

DATE OF BIRTH

8 / 27 / 1963
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?	☐	☐	☒
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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

MEDALL Scott

DATE

11-1-17

FORM REVIEWED BY

DATE

Did you bring your immunization record card with you?

yes ☐ no ☐

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FROM STUDENT HEALTH CENTER
TRAVEL HEALTH HISTORY

Date 11-1-17 Name MEGAN SCOTT

1. What is the reason for your visit today IMMUNIZATION
2. List allergies you have to medicines, foods or iodine: _____
3. List any medications or drugs you are currently taking (this would include herbal and over-the-counter as well as prescription drugs) GLUCOSAMINE CHONDROITIN; ANTIBIOTIC
4. Have you had any of the following: (circle if this applies to you);
Heart disease _____
Kidney disease _____
Stomach/Gastrointestinal disease _____
Diabetes/sugar _____
5. Are you immunocompromised? (Is there a problem with your immune system) Yes _____ No /
Thymus disorder (Myasthenia gravis, thymoma, thymectomy) _____
Spleen removed _____
Transplant recipient _____
Cirrhosis of the liver _____
Cancer _____
HIV _____
6. How often do you drink beer, wine, wine cooler, or liquor? (Please circle)
Never / Rarely / 1-2 times a week / 3-4 times a week / 5 or more times a week
7. Where are you going on your trip? SOUTH AFRICA
8. How long is your trip? Months _____ Days 14
9. When are you leaving on your trip? 11-10-17

FOR FEMALES ONLY

- A. Date of your last period? _____ Have you had a hysterectomy? YES _____ NO _____
- B. Are you currently pregnant? YES _____ NO _____
What is your due date? _____
- C. Do you plan to become pregnant in the next 3 months? YES _____ NO _____
- D. Are you breastfeeding? YES _____ NO _____

Refill: 1 2 3 5 PRN NR

Label all prescriptions

Dispense As Written

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

Product Selection Permitted

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

[Signature]

Malarone 250/100mg
Disp: 23
Sig: Take one pill a day. Begin 2 days before
departure, continue through stay and
for 7 days after return.

R

Address

Name

Medgar Scott

Date

11/1/17

Carol Stewart, C.R.N.P.
Lic. #1-045437
Rx: 1178

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

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