



INFECTION CONTROL FORM

Gift of Life
1348 Carmichael Way
Montgomery, AL 36106

Phone: 334-272-1820

Contact: Nancy Lee

Bill to: Gift of Life

Authorized by: Nancy Lee Date: 10/6/14

Employee Name: Lori D. Rogers

Auburn University Montgomery Nursing Care Center
Irma B. Moore Hall, Room 102
Montgomery, Alabama 36124
334-244-3281

Infection Control

Conduct the following titer/vaccine/testing:

Titers:

☐ MMR
☐ Varicella

Vaccines:

☐ MMR
☐ Tdap

Testing:

☒ TB

Please verify identity by
picture identification of
employee presenting this
form.

Lord Rogers

Tuberculin Test

Titer Test Results for Non Susceptibility (IgM)

[illegible]

ADOLESCENT & ADULT IMMUNIZATION RECORD

CLINIC:

STUDENT HEALTH CENTER

IRMA B. MOORE HALL RM. 102

P.O. BOX 244023

MONTGOMERY, AL 36124-4023

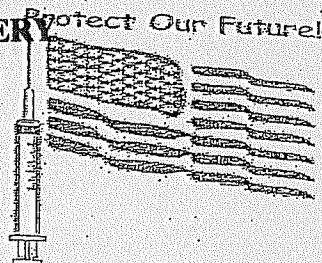
Name: Lori Rogers

Date of birth: 3/14/64 Record #

Allergies: NKMA

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*	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					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
IPV					Polio					0.5cc		SQ	
PPV23					PPV					0.5cc		IM	
PPV23					PPV					0.5cc		IM	
Hepatitis A	10	18	13	49	Hep A	10	11	ESK	9E2GN 09/30/15	1.0	LD	IM	AM
Hepatitis A	3	17	14		Hep A	10	11	ESK	9E2GN 09/30/15	1.0	LD	IM	AM
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:

Patient name:

Rogers, Lori

Date of birth:

03, 14, 64
(mo.) (day) (yr.)

Screening Checklist for Contraindications to Vaccines for Adults

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 weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, 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:

Lori Rogers

Date:

03-17-14

Form reviewed by:

Date:

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.

Carol Stewart, C.R.N.P.
Lic. #1-445437
Rx: 1178

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

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

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

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

Name Lori Rogers

Date 10/18/13

Rx

Vivotif
Disp: 4
Sig: Take as directed.

Label all prescriptions

Refill: 1 2 3 5 PRN NB

Product Selection Permitted

Dispense As Written

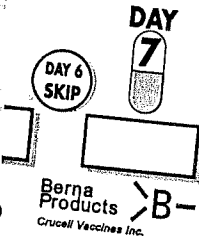
M.D. or C.R.N.P.

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

COT-V17-CVRS RV (03-07)

om Mirror

Vaccine



sed

wn

th care provider before
Before taking each
pen the blister pack and

aged. Consult your pharmacist. Use the foil blister pack or
mouth without food, usually every other day for 4 doses or
le whole with cold or barely warm liquid about 1 hour before
swallow with the liquid immediately. Do not chew, crush, or
sing schedule closely for the vaccine to be most effective.
keep track of when to take your next dose. You should
week before possible exposure to typhoid fever. You may
k for typhoid fever after 5 years. Ask your doctor or

ect persists or worsens, tell your doctor or pharmacist
scribed this medication because he or she has judged that
e effects. Many people using this medication do not have
tion to this drug is rare. However, seek immediate medical
us allergic reaction, including: rash, itching/swelling
hives, trouble breathing. This is not a complete list of
not listed above, contact your doctor or pharmacist.
de effects. The following numbers do not provide medical
ts to the Vaccine Adverse Event Reporting System
ay call Health Canada at 1-866-234-2345.

Watch Vivotif Video at
www.OraTyphoidVaccine.com

User's Guide for Travelers

Quick Reference for Do's and
Don't's on Back Panel

OVERDOSE: If overdose is suspected, contact a poison control center or emergency room immediately. US residents can call the US National Poison Hotline at 1-800-222-1222. Canada residents can call a provincial poison control center.

Patient name: Lori DuVal Rogers

Date of birth: 03 / 14 / 64
(mo.) (day) (yr.)

Screening Checklist for Contraindications to Vaccines for Adults

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 weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, 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? <u>flu 10/1/13</u>	☒	☐	☐

Form completed by: _____ Date: _____
Form reviewed by: _____ Date: _____

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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Montgomery, Alabama 36124-4023
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Fax: (334) 244-3243

This is to verify that a copy of the following records and/or lab results was given to

Lori DuVal Rogers on 8-12-03
Print Patient's Name Date

Description of record(s) copied: Immunization Record

Lori Rogers
Patient's Signature
8-12-03
Date

**AUM NURSING CARE CENTER
IMMUNIZATION RECORD**

PATIENT NAME: Lori Rogers

BIRTHDATE: 3/14/64

ALLERGIES/MEDICAL ALERT: -

NK m A

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

TUBERCULN TESTING PPD (MANTOUX) 0.1ml ID	DATE GIVEN	DATE READ	RESULTS	MFR	LOT #	COMMENTS	INITIALS
	7/23/02	7/26/02	0mm	Aventis	C1046AB	@ forearm	RB

INITIALS	SIGNATURE	INITIALS	SIGNATURE
RB	RBennett AUMMS		