



Hepatitis A Reminder

Date: 5/2/18

Dear E/450

Your final Hepatitis A vaccination is due on May 10, 2018.
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 May 24, 2018.

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

CLINIC:

Name: Elyse EvansDate of birth: 11/13/1989 Record #

Allergies:

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							SQ	
IPV					Polio							SQ	
IPV					Polio							SQ	
IPV					Polio							SQ	
PFV23					PPV					0.5cc		IM	
PFV23					PPV					0.5cc		IM	
Hepatitis A					Hep A					1.0	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:

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME _____

DATE OF BIRTH _____ / _____ / _____
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? <i>WPS</i>	☒	☐	☐
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? <i>flu</i>	☒	☐	☐

FORM COMPLETED BY *Elyse Evans* DATE *11/10/17*

FORM REVIEWED BY *[Signature]* 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.

AUM STUDENT HEALTH CENTER
TRAVEL HEALTH HISTORY

Date 11/10/17 Name Elyse Evans

1. What is the reason for your visit today travel Vaccinations
2. List allergies you have to medicines, foods or iodine: N/A
3. List any medications or drugs you are currently taking (this would include herbal and over-the-counter as well as prescription drugs): Plavix

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? Vietnam

8. How long is your trip? Months 0 Days 12

9. When are you leaving on your trip? 11/15

FOR FEMALES ONLY

A. Date of your last period? 10/30 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 ☒