

Patient name: Melissa Houghton Date of birth: 5 13 94 (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: Melissa Houghton

Date: 9-12-2015

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.

**AUM NURSING CARE CENTER
IMMUNIZATION RECORD**

PATIENT NAME: Melissa Houghton

BIRTHDATE: 5/13/63

ALLERGIES/MEDICAL ALERT: _____

IMMUNIZATION	DATE	SITE	DOSE	MFR	LOT #	COMMENTS	VIS/DATE	INITIALS
DPT								
DPaT								
DT								
Tdap Td BOOSTER	9/12/16	LD	0.5	SP	Adacel® NDC 49281-400-58 - U5458CA E 28SEP18		2/24/16	AM
MMR								
MR								
HIB								
HEPATITS B								
OTHER								

TUBERCULIN TESTING PPD (MANTOUX) 0.1ml ID	DATE GIVEN	DATE READ	RESULTS	MFR	LOT #	COMMENTS	INITIALS
	9/12/16	9/14/16	PPD	SP	C5022BA	(L) forearm	AM
	11/13/17			SP	C5154BA	(L) forearm	AM

INITIALS	SIGNATURE	INITIALS	SIGNATURE
AM	[Signature]		



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: 9-12-2016

Employee Name: Melissa Houghton

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.