

**AUM NURSING CARE CENTER
IMMUNIZATION RECORD**

PATIENT NAME: Paula Diaz BIRTHDATE: _____

ALLERGIES/MEDICAL ALERT: NKMA

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

TUBERCULIN TESTING PED (MANTOUX) 0.1ml ID	DATE GIVEN	DATE READ	RESULTS	MFR	LOT#	COMMENTS	INITIALS
	8/21/13	8/23/13	Qmm	SP	C4287BA	(2) fveeam AD	

INITIALS	SIGNATURE	INITIALS	SIGNATURE
AM	Ron		