

**AUM Student Health Services
Immunization Record**

Patient Name: Jarita Huffman

Birthdate: 10/17/83

Allergies/Medical Alert: _____

Immunization	Date	Site	Dose	MFR	Comments	Visit Date	Initials
Tdap							
Td Booster							
MMR							
HEP A							
HEP B							
Other							

	Date Given:	Date Read:	Results:	MFR	LOT#	Comments	Initials
Tuberculin Testing PPD (MANTOUX) 0.1 ml ID	1/16/18	1/19/18	0mm	SP	C5471AA	② forearm	AM

Initials	Signature	Initials	Signature
AM	[Signature] KN-BC		

**AUBURN UNIVERSITY MONTGOMERY
STUDENT HEALTH CENTER
IRMA B. MOORE HALL RM. 102
P.O. BOX 244023
MONTGOMERY, AL 36124-4023**

STAMP ABOVE

AUM Student Health Center
Vaccine Consent and Administration Record

Patient Information: Last Name First Name Date of Birth

Huffman Jarita 10/17/83

Address: 4132 Carmichael rd apt 435 Mont AL 36106

Phone: 334-294-3918 Primary Care Provider _____

Screening Questions:	Yes	No	Don't Know
1) Are you sick today? (cold, fever, acute illness)	☐	☒	☐
2) Do you have allergies to any foods, medications or latex? (For example: eggs, gelatin, neomycin, thimerosal.) List <u>Morphine</u>	☒	☐	☐
3) Do you take anticoagulation medicine? (Ex: warfarin, Coumadin or other blood thinners).	☐	☒	☐
4) Do you have any long-term health problems with heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g. diabetes), anemia, or other blood disorders?	☐	☒	☐
5) Have you had a seizure, brain or other nervous system problem? (Ex: Guillain-Barre syndrome?)	☐	☒	☐
6) For women: Are you pregnant or nursing? Could you become pregnant in during the next month?	☐	☒	☐

Consent for Services: I have been provided with the Vaccine Information Sheet corresponding to the vaccine that I am receiving. I have read or have had explained the information provided about the vaccine I am to receive. I have had the chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of vaccination and I voluntarily assume full responsibility for any reactions that may result. I request that the vaccine be given to me or the person named above for whom I am authorized to make this request.

Signature Jarita Huffman Date 1/16/18

Administration Date 1/16/18 Route: IM LD or RD Volume: 0.5cc

Administrator [Signature] VIS Date 8/7/2015

Manufacturer: GSK FluArix® Quadrivalent Lot # TL54R Expires 06/12/2018

LOT: TL54R
EXP: 06/12/18

NDC 58160-907-41

Influenza
Vaccine
FLUARIX® QUADRIVALENT
2017/2018 Formula 0.5 mL

Mfd. by
GlaxoSmithKline
Biologicals



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